



**GREENVILLE**  
CENTRAL SCHOOL DISTRICT

PO Box 129  
Greenville, NY 12083  
(518) 966-5070 ext. 305  
Fax: (518) 966-6033

HS/MS Nurse 518-966-5070 ext. 420  
Fax: 518-966-5338

Scott M. Ellis Nurse 518-966-5070 ext. 320  
Fax: 518-966-5321

**PARENT AND PRESCRIBER'S AUTHORIZATION FOR  
ADMINISTRATION OF MEDICATION IN SCHOOL**

A. To be completed by the parent or guardian:

I request that my child \_\_\_\_\_ grade \_\_\_\_\_ receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse will administer the medication or an adult will supervise my child taking his/her own medication.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

B. To be completed by the licensed health care prescriber:

I request that my patient, as listed below, receive the following medication:

Name of student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Prescribed Dosage, Frequency and Route of Administration: \_\_\_\_\_

Time to be taken during school hours \_\_\_\_\_

Duration of treatment: \_\_\_\_\_

Possible side effects and adverse reactions (if any): \_\_\_\_\_

Other recommendation: \_\_\_\_\_

Name of Licensed Prescriber and Title (please print): \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_