HARRISON CENTRAL SCHOOL DISTRICT

PARENT AND PRESCRIBER'S AUTHORIZATIONFOR ADMINISTRATION OF MEDICATION IN SCHOOL

A. To be completed by the parent or guardian:

I request that my child_____grade_____ receive medications as prescribed. The medication is to be furnished by me in a pharmacy labeled bottle. I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication. PLEASE NOTE HARRISON CENTRAL SCHOOL DISTRICT POLICY RE: CONTROLLED SUBSTANCE MEDICATION. **AN ADULT SHOULD DELIVER ALL MEDICATION TO THE SCHOOL NURSE. STUDENTS SHOULD NOT BE CARRYING MEDICATION TO SCHOOL. IN THE CASE OF A MEDICATION TERMED A "CONTROLLED SUBSTANCE" (SUCH AS RITALIN, ADDERALL, DEXEDRINE, ET AL) THE MEDICATION MUST BE COUNTED AND <u>SIGNED FOR</u> BY THE NURSE AND THE ADULT DELIVERING IT.**

Signature (Parent or Guardian):_____

Address:_____

Telephone: Home_____Work_____Date_____

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:_____DOB:_____

Diagnosis:_____

Name of Medication:_____

Prescribed Dosage and Frequency:_____

Time to be taken during school hours:_____

Name of Licensed Prescriber and Title:_____
(Please Print)

Prescriber Signature:_____Date:_____

Address:_____Phone_____