Cleary School ForThe Deaf

301 Smithtown Blvd., Nesconset, NY 11767
631-588-0530; 631-588-0016 (fax)

PARENT & PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION & NURSING SERVICES IN SCHOOL & SCHOOL ACTIVITIES

A. To be completed by parent/guardian:

I request that my child _____DOB _____receive the medication/nursing service as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy*.

Signature (Parent/Guardian): _____Date: _____

* Medication must be in original pharmacy labeled container with specific orders and name of medication.
* Medication and refills must be brought in by parent/guardian or transported via locked medication case.

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

Student's Name: _____DOB: _____

Diagnosis: _____

MEDICATION/ NURSING SERVICE	DOSAGE	FREQUENCY/ TIME	ROUTE	ICD-10 CODE

Duration of Treatment: 7/3/17 – 6/30/18 (2017 – 2018 school year)
(mm/dd/yy – mm/dd/yy)

Possible Side Effects and Adverse Reactions (if any):

_____

(Physician's Stamp) ↓

Physician's Signature: _____
(Full signature in ink)

Print Physician's Name: _____

Physician's NPI #: _____

Physician's License: _____

Today's Date: _____

The above Plan reviewed with parent/guardian:
Parent/Guardian Signature: _____ Date: _____

The original of this form must be maintained in the school's health office.