SCS
SMITHTOWN
CHRISTIAN SCHOOL

PHYSICIAN'S ORDER FOR GIVING MEDICATION IN SCHOOL

Student's Name_____Address_____

Parents or Guardian_____

TO PHYSICIANS AND PARENTS OF CHILDREN REQUIRING MEDICATION IN SCHOOL

In compliance with the rules and regulations of the New York State Education Department, you are requested to complete this form so the required medication may be administered in school to your child.

NAME OF DRUG_____

GENERIC NAME OF DRUG, IF POSSIBLE_____

DOSAGE AND FREQUENCY_____

EXPECTED EFFECT_____

POSSIBLE SIDE EFFECTS_____

DIAGNOSIS_____

TIME DURATION OF ORDER_____DAYS_____MONTHS_____

DATE ORDER IS EFFECTIVE_____

	_____ Physician's Signature
	_____
Physicians Stamp	Telephone Number Date

PARENT REQUEST TO SCHOOL TO GIVE MEDICATION

I, hereby, request that my child, _____be given the medication
(FULL NAME)

above as prescribed by the physician. We, the parents, authorize the school to assist our child in taking medication and agree that we will not hold liable any member of the school staff or an individual of official capacity who is directed by us (the parents) and the school administrator to assist our child in taking said medication.

_____
Parent/Guardian Signature

Received by _____ Quantity _____ Expiration _____

Updated 1/4/19