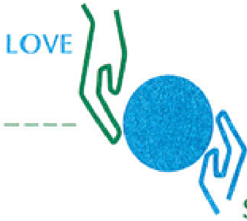

Cleary School for the Deaf

301 Smithtown Boulevard, Nesconset, New York 11767-2077 631-588-0530 (V & TTY)
www.clearyschool.org 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 my child ______________________________ Date of birth ______________
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 the 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: ______________________________ Date of birth: ______________

Diagnosis: ____

MEDICATION/ NURSING SERVICE	DOSAGE	FREQUENCY/ TIME	ROUTE	ICD-9 CODE

Duration of treatment (mm/dd/yy - mm/dd/yy): ______________________________

Possible Side Effects & Adverse Reactions (if any): ______________________________

____ **(Physician's Stamp)** ⇩

Physician's Signature: ______________________________

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