LOVE SERVICE
Cleary School for the Deaf
301 Smithtown Boulevard, Nesconset, New York 11767-2077 631-588-0530 (V & TTY)
www.clearyschool.org

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: _____

<u>The original copy of this form must be maintained in the school's health office.</u>