O|L|L

OUR LADY OF LOURDES SCHOOL

44 Toomey Road, West Islip, New York 11795
Phone 631.587.7200 Fax 631.587.4531

School Health Services

PARENT AND HEALTHCARE PROVIDER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

A. **To be completed by the parent or guardian**:

I request that my child_____ DOB _____
receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy.*

Parent Signature _____ Date_____

B. **To be completed by the Private Healthcare Provider**:

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

Student's Name_____DOB_____

Diagnosis_____

Medication_____

Dosage_____Route_____Frequency_____

Time to be taken during school hours_____

Possible side effects or adverse reactions (if any):

_____

Health Care Provider's
signature:_____Date_____

Physician Information: (Please Stamp)

This medication order is valid for the current school year and summer school as needed.

*Medication must be in original pharmacy labeled container with specific orders and name of medication.
*Medication and refills must be brought to school by parent, guardian or responsible adult..