

GREAT NECK PUBLIC SCHOOLS
Health Services
Physician's Order / Parent Authorization for Administration of Medication

SCHOOL _____

DATE _____

GRADE _____

PHYSICIAN'S ORDER

TO BE COMPLETED BY PHYSICIAN:

PLEASE ADMINISTER TO MY PATIENT: _____

THE FOLLOWING MEDICATION AS INDICATED:

MEDICATION _____

DOSAGE _____

TIME _____

SIDE EFFECTS, IF ANY _____

Physician's Signature & Stamp

Date

PARENT AUTHORIZATION

TO BE COMPLETED BY THE PARENT OR GUARDIAN:

I request that my child, _____, grade _____, receive the medication (Prescription or Over the Counter) prescribed by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse or other assigned person will administer the medication.

Parent or Guardian Signature

Date