380 Washington Ave Roosevelt, NY 11757
Phone: 516-378-2000 Ext. 280 Fax: 516-377-2081

PARENT/PHYSICIANS AUTHORIZATION FORM FOR ADMINISTRATION OF MEDICATION/TREATMENT IN SCHOOL AND SCHOOL ACTIVITIES

PERIOD OF SCRIPT

July 1, 2024 to June 30, 2025

Student's Name: _____ * _____

Date of Birth: _____ Parent/Guardian Signature
Firma Del Padre/Tutor

Medication Name & Strength: _____

Dose: _____ Route: _____

Time/Frequency/for what symptoms: _____

If PRN, frequency to be given at school/for what symptoms: _____

Medication Name & Strength: _____

Dose: _____ Route: _____

Time/Frequency/for what symptoms: _____

If PRN, frequency to be given at school/for what symptoms: _____

Medication Name & Strength: _____

Dose: _____ Route: _____

Time/Frequency/for what symptoms: _____

If PRN, frequency to be given at school/for what symptoms: _____

Physician's Name (Print) _____ Physician's Signature: _____

Physician's License # (Required): _____ Physician's NPI # (Required): _____

Telephone #: _____ Date: _____

Physician's Stamp (Required):