Glens Falls Pediatric Consultants, P.C.

Pediatric Associates of Saratoga

PERMISSION TO ADMINISTER MEDICATION IN SCHOOL

IT IS NECESSARY THAT BOTH SECTIONS BE COMPLETED BEFORE MEDICATION IS DISPENSED:

TO BE COMPLETED BY THE PHYSICIAN:

I request that my patient receive the following medication, administered by the School Nurse or authorized school personnel during school hours:

NAME OF STUDENT _____ DOB _____

DIAGNOSIS _____

Name of medication, dosage, time, and route of administration:

_____

_____

Duration of treatment: _____ School Year

_____ To be discontinued on _____

Potential Side effects: _____

Physician (prescriber's) signature _____ Date _____

Please print name and title _____

Physician's stamp

TO BE COMPLETED BY THE PARENT/GAURDIAN:

I REQUEST THAT MY CHILD _____ cluster _____, grade _____, receive the medication(s) at school as prescribed by the above health care provider.

Parent/guardian _____ Date _____

(Please Print)

Parent/guardian _____

(Signature)

Pediatric & Adolescent Medicine

154 Warren Street • P.O. Box 141 • Glens Falls, New York 12801 • Telephone: (518) 798-9985 • Fax: (518) 761-7043
4 Carpenter Lane • Saratoga Springs, New York 12866 • Telephone (518) 587-3823 • Fax: (518) 587-6677