

**BROOKLYN FRIENDS SCHOOL
MEDICATION ADMINISTRATION FORM**

Parent and Physician's Authorization for Administration of Medication in School and School Activities, School Year 2009-2010

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

Name of Student _____ Age _____ Date of Birth _____

Grade _____ Classroom Teacher/Advisory _____

TO BE COMPLETED BY PARENT/GUARDIAN

Print your name: _____ Phone(s) _____

I request that my child _____, receive the medication as prescribed below by our physician. The medication is to be furnished by me in the original pharmacy labeled container with specific orders and name of medication.

Signature _____ Date _____

TO BE COMPLETED BY PHYSICIAN

I request that my patient, _____ Date of Birth _____ receive the following medication.

Medication	Dosage	Frequency/Time to be taken	Route of Administration

Duration of Treatment _____ Diagnosis _____

Possible Side Effects and Adverse Reactions (if any) _____

Physician Signature _____ Date _____

Physician Stamp

Address _____ Phone _____

I acknowledge that I have reviewed this plan with the School Nurse.

Parent/Guardian Signature _____ Date _____

School Nurse Signature _____ Date _____