ST. JOHN THE BAPTIST DIOCESAN HIGH SCHOOL

1170 MONTAUK HIGHWAY | WEST ISLIP, NY 11795-4959
(631) 587 – 8000 ext. 123 FAX (631) 587 – 8996

HEALTH OFFICE
Kristina Mezzacappa, RN Jennifer Tomeo, RN

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 _____Grade_____ 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: (**MUST HAVE MD 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. *ALL MEDICATIN MUST BE PICKED UP IN JUNE. NO MEDICATION CAN BE STORED OVER THE SUMMER.*