Trinity Regional School

1025 5th Avenue • East Northport, N.Y. 11731
(631) 261-5130

ADMINISTRATION OF MEDICATION IN SCHOOL

To be completed by Parent/Guardian:

Student Name: _____ Date of Birth: _____

I request that my child in grade _____ receive the medication as prescribed below by our licensed heath care provide. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse will administer the medication or an adult will supervise my child taking his/her medication:

_____ _____
Signature Parent/Guardian Date

_____
Address

_____ _____ _____
Home Phone Cell Phone Work Phone

To be completed by the Licensed Heath Care Provider:

I request that my patient, as listed below, rece ve the following medication in school:

Student Name: _____ Date of Birth: _____

Diagnosis: _____

Medication: _____

Dosage/Frequency/Route of Administration: _____

_____

Time to be taken during school hours: _____

Duration of Treatment: _____

Possible side effects/adverse reactions: _____

Other Recommendations: _____

_____ _____ _____
Prescriber's Name and Title (please print) ***Phone*** ***Date***

_____ _____
Signature ***Address***

Dr. Stamp