Liberty Central School District

2025-2026

PARENT AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

A. To be completed by the parent or guardian:

I request that my child____**Grade**_____ receive the medication as prescribed below by our licensed health care provider. The medication is to be furnished by me in a properly labeled original container from the pharmacy. I understand that the school nurse, or other designated person in the case of the absence of the school nurse will administer the medication.

Parent/Guardian Signature: ____

Address: ____

Home # _________________Work # _________________Cell # _________________ Date _________________

B. To be completed by the licensed health care prescriber:
I request that my patient, as listed below, receive the following medication.

Name of Student______________________________________ Date of Birth___________________________

Diagnosis____

Name of Medication____

Prescribed Dosage, Frequency & Route of Administration____

Time to Be Taken During School Hours____

Duration of Treatment ____

Possible Side Effects and Adverse Reactions (if any) ____

Other Recommendations ____

Name of Licensed Prescriber and Title (please print) ____

Prescriber ____

Signature ____

Date _________________________

Address ____ Phone _______________________