# *Bishop Dunn Memorial School*

*Located on the Mount Saint Mary College Campus*
*50 Gidney Avenue, Newburgh, New York 12550*
*(845) 569-3494 Fax (845) 569-3303 www.bdms.org*
*Mrs. Nancy Benfer, Principal*


## 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 prescriber. 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 own medication.

Name of Student: _____ Date of Birth: _____
Parent's Name: _____Signature: _____
Address: _____
Telephone: (Home) _____ (Work) _____Date: _____

**B. To be completed by the licensed health care prescriber:**

I request that my patient, as listed above, receive the following medication:
Diagnosis:_____
Name of Medication:_____
Prescribed Dosage, Frequency and Route of Administration:_____
Time to be taken during School Hours:_____
Duration of Treatment: _____
_____
Possible Side Effects and Adverse Reaction (if any):
_____
_____
Self-carry:
Yes
No
Other Recommendations:_____
Name of licensed Prescriber and Title (please print): _____
Prescriber's Signature: _____Date: _____
Address:_____Phone:_____