the king's school

Preparing Tomorrow's Leaders Today

Authorization for Administration of Medication at The King's 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 medications are to be provided to the school by me in the original container, with the child's name and date clearly labeled. I understand that the school nurse will administer the medication or an adult will supervise my child taking his/her own medication as ordered.

Signature (Parent or Guardian): _____

Address: _____

Telephone: Home: _____Work: _____ Date: _____

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

I request that my patient, as listed below, receive the following:

Name of student: _____ DOB: _____

Diagnosis (if applicable):_____

Name of Medication: _____

Indication for Medication: _____

Check the one that applies: [ ] DAILY MEDICATION [ ] AS NEEDED MEDICATION

Dose:_____ Frequency: _____ Route of Administration: _____

Time to be taken during school hours: _____

Duration of Treatment:_____

Possible side effects and adverse reactions (if any): _____

Other recommendations : _____

Licensed Prescriber and Title (please print): _____

Prescriber's
Signature: _____ Date:_____

Address: _____ Phone: _____

A Ministry of Church of the Nations
PO Box 300, Lake Luzerne, NY 12846-0300 – 518.654.6230 – Fax 518.654.7310
main_office@kingsschool.info – www.kingsschool.info