GREAT NECK PUBLIC SCHOOLS
Health Services
Physician's Order / Parent Authorization for Administration of Medication

SCHOOL _____

DATE _____

GRADE _____

PHYSICIAN'S ORDER

TO BE COMPLETED BY PHYSICIAN:

PLEASE ADMINISTER TO MY PATIENT:_____

THE FOLLOWING MEDICATION AS INDICATED:

MEDICATION _____

DOSAGE _____

TIME _____

SIDE EFFECTS, IF ANY _____

_____
Physician's Signature & Stamp

_____
Date

PARENT AUTHORIZATION

TO BE COMPLETED BY THE PARENT OR GUARDIAN:

I request that my child, _____, grade_____, receive the medication prescribed 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 or other assigned person will administer the medication.

_____
Parent or Guardian Signature

_____
Date