בס"ד

ישיבת ל"ב HALB

THE HEBREW ACADEMY OF LONG BEACH

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Authorization for Administration of Medication in School including over the counter medications such as Tylenol, Advil and Benadryl

To Be Completed by the Parent or Guadian:

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 a designated adult will supervise my child taking his/her own medication.

Signature (Parent or Guardian): ______________________________ Date: __________

Address: ____

Telephone: Home ________________ Work ____________________ Cell ______________

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 and 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's Signature: ____

Address: ____________________________________ Phone : ____________________