

**WESTERN NEW YORK PEDIATRIC ASSOCIATES
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AUTHORIZATION TO ADMINISTER MEDICATION IN SCHOOL

In compliance with the requirements of the University of the State of New York relative to internal medication by school personnel, we hereby request the school nurse to follow the instructions in the treatment of:

NAME OF STUDENT:

DOB:

Signature of Parent

Date

PHYSICIAN'S INSTRUCTIONS:

NAME OF MEDICATION:

DOSAGE AND FREQUENCY OF MEDICATION:

TIME TO BE ADMINISTERED:

REASON FOR MEDICATION:

ANY OTHER PERTINENT INFORMATION:

PHYSICIAN'S SIGNATURE

DATE

IT IS RECOMMENDED THAT THE MEDICATION BE BROUGHT TO THE SCHOOL NURSE BY THE PARENT.