Elmwood Village Charter School
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124 Elmwood Avenue, Buffalo, NY 14201 • www.elmwoodvillageschool.org

Parent and Physician Authorization for Administration of Medication

A. To be completed by the parent or guardian:

I request that my child ______________________________DOB ____________ receive the medication at school as prescribed below by our physician. ***The medication is to be furnished by me in the original container, properly labeled from the pharmacy*.*** I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication, including field trips.

Signature (Parent or Guardian): ____

Telephone: Home ___________________ Work __________________ Date _____________

B. To be completed by physician:

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

Name of Student _____________________________________ DOB ____________________

Diagnosis: ____

*MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment (Dates): ____

Possible Side Effects and Adverse Reactions (if any): ________________________________

Physician's Signature _______________________________ Date: _____________________

Address: ____ Phone: ____________________

* Medication must be in original pharmacy labeled container. Medication and refills must be brought to school by parent, guardian or responsible adult.