MORRIS CENTRAL SCHOOL

PO BOX 40
65 MAIN STREET
MORRIS, NEW YORK 13808

PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

A. To be completed by the parent or guardian:

I request the my child _____ DOB _____ receive the medication as prescribed below by our physician. **The medication is to be furnished by me in the properly labeled ORIGINAL container from the pharmacy. This includes both prescription and non-prescription medication. Morris Central School does not provide any medications.**

* All medication and refills must be brought to school by parent, guardian, or a responsible adult.

Signature (parent or guardian) _____ Date _____

Telephone: Home _____ Work _____ Cell _____

B. To be completed by a 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	SELF CARRY YES/NO

Physician's Signature _____ Date _____

Address _____ Phone _____