

**A: Needed medication order and authorization:**

**1. To be completed by physician:**

Students name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Name and dosage of medication: \_\_\_\_\_  
Route and frequency of medication: \_\_\_\_\_  
Rationale for as needed (prn) medication: \_\_\_\_\_  
Signature of ordering provider : \_\_\_\_\_  
Printed name of ordering provider: \_\_\_\_\_  
Today's date: \_\_\_\_\_ Contact #: \_\_\_\_\_

**2. To be completed by parent/legal guardian:**

I, \_\_\_\_\_, give parental consent that my child  
\_\_\_\_\_ grade \_\_\_\_\_ may receive any and all medications that  
are prescribed by a licensed health care provider while at school by the school nurse.

Signature of parent/legal guardian: \_\_\_\_\_  
Printed name of parent/legal guardian: \_\_\_\_\_  
Today's date : \_\_\_\_\_ Contact # : \_\_\_\_\_

Please return completed form to the health office. 😊

Thank you. Please call with any questions.

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