MOUNT SINAI UNION FREE SCHOOL DISTRICT
P.O. BOX 397, NORTH COUNTRY ROAD
MOUNT SINAI, NEW YORK 11766

PARENT/PHYSICIAN AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

FOR

IN-SCHOOL USE AND SCHOOL TRIPS

A. To be completed by Parent/Guardian: **Grade Level** _____

I request that my child, _____, receive the medication as prescribed by my physician.

Name of Parent/Guardian *(Please print.)*: _____

Signature of Parent/Guardian: _____ Date: _____

Home Phone: _____ Cell Phone: _____

B. To be completed by Physician:

Allergies: _____

I request that my patient, as listed below, receive the following medication (prescription and over-the-counter):

Name of Student (*Please print.*): _____

1. Diagnosis: _____ Medication: _____

   Dosage, Frequency, Route, Time & Side Effects:

   _____

   _____

2. Diagnosis:_____ Medication: _____

   Dosage, Frequency, Route, Time & Side Effects:

   _____

   _____

Name of Physician *(Please print.)*: _____

Address: _____

Signature/Stamp: _____ Date: _____

This form must be completed for students to carry and administer their own medication (prescription and over-the-counter) in school and on school trips along with the Self-Medication Release Form (A or B as applicable).

Updated 9/2015