A member of the YAI network.

180 Amsterdam Avenue, 3rd Floor   New York, NY 10023   Telephone (646) 795-3850   Fax: (212) 602-0198

Authorization for the Administration of Medication

Name of Student: ______________________________DOB:______________
Address: _____________________________________Phone: _____________
____
School: ___________________________Teacher:________________________

Part 1 – Physician's Statement:

1. **Name/ type of medication: __________________________________**
2. **Dosage/amount to be given: __________________________________**
3. **Frequency/times to be given: ________________________________**
4. **Duration (week, month, school year, etc, ______________________**
5. **Anticipated reaction to medication: ___________________________**
   ____

____
Physician's Signature/License #   Address   Phone #   Date

Part 11 – Parents Request/Approval

I hereby request and give permission for the above named school to administer the medication prescribed on this form to my child.

____
Parent's Signature **Date**

PART III – Designated Person(s) Administering Drugs:

I have agreed to administer the medication as requested by the parent and in the accordance with directions listed by the physician.

____
____

____
Signature of Person(s) Administering Medication **Date Signed**

PART IV – Remarks:
____
____