CENTER FOR SPECTRUM SERVICES
Brightening the lives of people with autism

70 Kukuk Lane
Kingston, NY 12401
tel: 845.336.2616
fax: 845.336.4153

4 Yankee Place
Ellenville, NY 12428
tel: 845.647.6464
fax: 845.647.3456

Jamey Wolff Program Director **Susan Buckler** Administrative Director
web: www.centerforspectrumservices.org

PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

Name of Student:_____ Date of Birth: _____

A. To be completed by the parent or guardian:

I request that my child receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse, or other assigned person will administer the medication.

Signature (Parent or Guardian):_____ Date: _____

B. To be completed by the licensed health care prescriber:

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

Diagnosis:

Name of Medication(s):

Prescribed Dosage, Frequency, Time and Method of Administration:

_____

_____

Check ALL possible:

____During School Hours _____While on Community Trips

____Can be missed at school if on an all day outing.

____Can be administered at school upon returning from outing.

____May administer A.M. dose at school if missed at home

Duration of Treatment:

Possible Side Effects and Adverse Reactions (if any):

Other Recommendations:

Name of Licensed Prescriber and Title (please print):_____

Prescriber's Signature:_____**Date:**_____

PHYSICIAN'S STAMP HERE: