Hornell City School District
Medication in School

To: Physicians and Parents of Children requiring medication in school

In compliance with the rules and regulations of the New York State Education Department, you are requested to complete this form so that required medication may be administered in school to your child (patient).

Student's Name: _____

Name of Drug(s):_____

Generic Name of Drug(s) if possible: _____

Dosage and Frequency: _____

Expected Effect(s):_____

Possible Side Effect(s):_____

Diagnosis AND ICD Code: _____

Date Order is Effective: START DATE: _____END DATE: _____

Physician's Signature: _____DATE:_____

Physician's Address: _____Phone #:_____
(preprinted or office stamp is acceptable above)

Physicians NPI AND License #:_____

Parent/Guardian Request for School to give Medication(s):

I hereby request that my child, _____ be given the medication(s) above as prescribed by the physician.

Parent/Guardian Signature: _____DATE:_____

Phone #s: Work: _____Home:_____ Cell: _____