



La Salle Institute

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Authorization to Administer Internal Medication by School Personnel

Please Complete BOTH sections, A & B

A. For Parent

I, _____ request the School Nurse, or other
Name of Parent or Guardian

Authorized personnel, administer to _____
Name of Student

The medication prescribed by _____
Name of Physician

Parent/Guardian Signature

Date Signed

B. For Physician

This is to certify that _____ is being attended and treated by
Name of Student

myself. It is essential that he/she be given the following medication in the dosage indicated during the school hours for treatment of: _____

Name of Medication (or other identification): _____

Dosage Schedule: _____

Possible Side Effects: _____

Length of time to be given: _____ - _____ School Year

Physician Signature

Address

Date Signed

It is the parent's responsibility to see that the school receives this authorization

A parent/guardian must drop off medication to the school nurse

This form must be renewed yearly

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