SCARSDALE MIDDLE SCHOOL
HEALTH OFFICE
134 Mamaroneck Road
Scarsdale, NY 10583
Tel# (914)721-2610
Fax# (914)722-2850

Authorization for Administration of Medication:

Dear Parents:

As per New York State Law, **any and all** medications must be prescribed by a physician **and** approved by a parent in order for the school nurse to administer. **The medication is to be furnished to the school nurse in its original container properly labeled**. Thank you for your cooperation.

Student: _____ Grade: ____ House: _____

This is to certify that the above student may take:

Physician to complete table below:				
Medication	**Dosage**	**Time**	**Reason**	**Check here:** ☑ if student may carry & self-administer own **Inhaler**, **Epipen** & **Diabetic Supplies only.**

Parent's Signature _____ Date _____
(required)

– **AND** –

Physician's Signature _____ Date _____
(required)

Tel # _____

PHYSICIAN'S Address stamp:

2/2/18