GREAT NECK PUBLIC SCHOOLS
Health Services
Parent Authorization for Administration of Medication

PARENT AUTHORIZATION

TO BE COMPLETED BY THE PARENT OR GUARDIAN:

I request that my child, _____, grade_____, receive the medication (Prescription or Over the Counter) prescribed 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.

_____
Parent or Guardian Signature

_____
Date