463 Hawthorne Avenue
Yonkers, NY 10705
914-375-8700

1529-35 Williamsbridge Road
Bronx, NY 10461
718-794-8200

RisingGround.org

The Biondi School

SCHOOL MEDICATION PRESCRIBER AUTHORIZATION

Student Name: ______________________________ **DOB:** ________ **Sex:** ______

List any known allergies/reactions:
____
____

Physician Name: ______________________________
Physician Address: ______________________________
Physician Telephone and Fax: ______________________________

Name of Medication: ______________________________
Reason for Taking: ______________________________
Dosage Route Frequency Time(s) to Be Given ______________________________
Begin Medication ______________ Stop Medication ______________
Date Date
Potential Side Effects/Contraindications/Adverse Reactions ______________________________

Name of Medication: ______________________________
Reason for Taking: ______________________________
Dosage Route Frequency Time(s) to Be Given ______________________________
Begin Medication ______________ Stop Medication ______________
Date Date
Potential Side Effects/Contraindications/Adverse Reactions ______________________________

Name of Medication: ______________________________
Reason for Taking: ______________________________
Dosage Route Frequency Time(s) to Be Given ______________________________
Begin Medication ______________ Stop Medication ______________
Date Date
Potential Side Effects/Contraindications/Adverse Reactions ______________________________

Special Instructions:

Does medication require refrigeration? Yes No
Is the medication a controlled substance? Yes No
If asthma inhaler or emergency medication, do you recommend this medication be kept "**on person**" by the student? Yes No
Treatment Order in the event of an adverse reaction: (Attach additional sheet or use the back of this form if necessary)

If PRN medication is prescribed for student. please attached order for each PRN medication with medication name, dose, frequency, route and indications.

For FEMALE students during menses, if PRN medication is advised, please provided order with medication name, dose, frequency, route and indications.

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Physician Signature **Physician Stamp** **Date**