The New LIFE School
Strengthening Lives, Families, Communities
Intermediate School
And
High School
831 Eagle Avenue
Bronx, NY 10456
P: (718) 665-2760

All medical information must be completed by the Prescribing Doctor:

Student:_____ Date:_____

Please list the medications that your child is prescribed to take over the course of an entire day (24 hours).

Medication: **Dosage:** **Exact Time of Day Medication is Given:**

1._____

2._____

3._____

4._____

Name of Medication:_____
Possible Side Effects:_____
Dosage:_____ Frequency:_____Time:_____

Name of Medication:_____
Possible Side Effects:_____
Dosage:_____ Frequency:_____Time:_____

Name of Medication:_____
Possible Side Effects:_____
Dosage:_____ Frequency:_____Time:_____

Name of Medication:_____
Possible Side Effects:_____
Dosage:_____ Frequency:_____Time:_____

DOCTOR AUTHORIZATION TO TAKE MEDICATION IN SCHOOL:

I request that my patient _____, receive the medication listed above during the **school day hours.**

Prescribing Doctor: _____Date:_____
Hospital/Agency Affiliation:_____
Address:_____
Phone:_____Fax:_____

PARENT AUTHORIZATION TO TAKE MEDICATION IN SCHOOL:

I request that my child_____ receive medication as prescribed above by the above listed Psychiatrist. The medication is to be furnished by myself, the guardian, in the original container from the pharmacy. It is my responsibility to provide this medication and its refill each month to the school. I understand that the school administrator, will oversee my child's medication, and ensure that an adult will supervise him/her taking the medication.

Guardian Signature:_____Date:_____