Fax Completed Form to:
631-632-6936, ATTN: Nurse Manager

Stony Brook University

STUDENT HEALTH SERVICES
Tel: (631) 632-6740

Student Information (to be completed by student)

STUDENT LAST NAME (PLEASE PRINT) | FIRST NAME | MIDDLE NAME (optional)

DATE OF BIRTH | STONY BROOK ID#

CELL PHONE

EMERGENCY CONTACT | RELATIONSHIP | PHONE

This Medication Administration Request Form must be completed by your practitioner and must be received by the Student Health Services before medications can be administered. If you are under the age of 18 the consent for treatment on this form must be signed by your parent or legal guardian.

FOR TREATMENT OF STUDENTS UNDER 18 YEARS OF AGE. To ensure prompt medical care when issues arise, we ask that parents or legal guardians sign the following statement: I authorize the healthcare practitioners and nurses of Stony Brook University Student Health Services to assess, treat, or arrange a referral to an external facility for the individual in my care in the event of illness or injury. Additionally, I authorize the administrations of vaccinations when deemed necessary for treatment or prevention of illness.

SIGNATURE OF PARENT OR GUARDIAN | RELATIOSHIP | PHONE | DATE

MEDICATION ADMINISTRATION REQUEST FORM:

Prescribing providers please complete this form to request medication administration for your patient here at Stony Brook University Student Health Services.

1. Please provide detailed information regarding the medication order for administration.
2. Orders from external providers must be tailored to the patient, include clear instructions, have a start and end date (not exceed 12 months), and be signed and stamped by the provider.
3. Please be aware that this order necessitates **annual renewal** to continue medication administration.

Please be advised that requests for medication administration will not be accepted for allergy immunizations.

Prescribing Provider Medication Order:

Patient Name:_____

Date of Birth:_____

Order Start Date:_____ Order Stop Date:_____ (not to exceed 12 months)

Medication:_____

Dose:_____

Route:_____

Frequency:_____

Additional Instructions:

I have reviewed all sections of this Health Form. I acknowledge to the best of my knowledge, that the information on this form is accurate and correct.

SIGNATURE OF PRESCRIBING PROVIDER ☐ MD ☐ PA ☐ NP | DATE: | PRINT NAME

OFFICE ADDRESS _____ *PRACTITIONER STAMP:*

_____

OFFICE PHONE NUMBER: _____

PLEASE REMEMBER TO MAKE A COPY OF THIS FORM FOR YOUR RECORDS BEFORE YOU SEND IT IN.

FOR INTERNAL OFFICE USE ONLY:

☐ Reviewed by Supervising NP Supervising NP Initial: _____ Date:_____