Marcus Whitman Central School District
Middlesex Valley Primary School 585-554-4802 x2 Fax 554-6172
Gorham Intermediate School 585-526-6351 x2 Fax 526-4435
Middle/ High School 585-554-6441 x4 Fax 554-4810

Medication Administration During School Hours

Part I: To be completed by Parent/Guardian

I authorize the school medical personnel to see that my child, _____,

receives the medication prescribed by _____(See below)

_____ _____

(Parent's /Guardian's Name --Please print) (Phone Number)

_____ _____

(Parent's /Guardian's Signature) (Date)

Part II: To be completed by Physician

Diagnosis:_____

Medication: _____ Dose:_____ Route: _____ Time/Frequency: _____

Duration of treatment: _____ Possible side effects and adverse reactions: _____

_____

_____ _____ _____

(Physician's name—please print) (phone number) (fax number)

_____ _____

(Physician's Signature) (Date)

*****Has been instructed in & understands the purpose & appropriate method & frequency of use & is permitted to carry the medication in the original container on his/her person as we consider him/her responsible**
YES_____ NO_____