SENECA FALLS CENTRAL SCHOOL DISTRICT
AUTHORIZATION FOR ADMINISTERING MEDICATION/SKILLED NURSING

The Seneca Falls Central School District requires all students receiving any medication during schools hours, whether prescription, over-the-counter or homeopathic, to have the following information and meet the following requirements:

(1) this form completed with any additional necessary information from the physician; (2) ALL medication must be in the **original prescription bottle** and properly labeled; (3) prescribed over the counter medication must be in the manufacturer's container; (4) ALL medication must be provided by the parent and kept in the school office unless the physician has designated that the student may carry the medication; and (5) parents must deliver all medication to school unless the physician's order specifies that the student is to carry the medication.

School _____

Student_____**Grade**_____**D.O.B.** _____

PHYSICIAN'S STATEMENT – To be completed by physician:

Name/Type of medication:_____

Reason for medication (Diagnosis)_____**ICD 10 Code:** _____

Form of medication/treatment: (Please check appropriate form of treatment)

Tablet/Capsule___ **Liquid**___ **Inhaler/Nebulizer**___ **Topical** ___ **Injection** _____ **Other**_____

Schedule and Dosage to be given at school: _____

Start Date:_____ **Stop Date:**_____

Restrictions and/or important side effects: **None Anticipated**____**If anticipated, please describe**_____

Is this child allergic to any medication: **Yes**_____**No**_____**If yes, what medication?** _____

This student may carry their inhaler and is capable of self-administration: **Yes**_____ **No**_____
(Students are not allowed to possess controlled substances at school.)

This student may self-carry and self-administer on school-sponsored events: **Yes**_____ **No**_____

Physician's Signature_____**License #:**_____ **Date** _____

Address_____**NPI #:**_____**Phone #**_____

If required, please send an EPIPEN that will not expire during the school year.

PARENT/GUARDIAN PERMISSION

School policy prohibits students from possessing any type of medication in school, including over-the-counter medication unless prescribed by a physician.

I give my permission for my child to receive the above named medication at school. I understand that the medication will be administered to my child by the authorized staff person (i.e. secretary, principal, school nurse, or other designated individual). *I understand that the use of self possessed and self administered medication (i.e. inhalers) will NOT be supervised or monitored by school personnel.* I agree that you may contact the physician who prescribed the medication and I hereby authorize her/him to release to you any information concerning my child's condition and treatment related to the use of this medication. Further, I understand and agree that I will not send medication to school with my child but will deliver it myself.

_____ _____ _____

Parent/Guardian Print Name **Parent/Guardian Signature** **Date**

My child may self-carry and self-administer on school-sponsored events: **Yes**_____

Home Address _____

Home Phone #_____ **Work Phone #**_____