Dansville Central School

Authorization for administration of Medications in School

A: To be completed by the parent or guardian:

I request that my child ______________________ DOB_________receive the medications as prescribed below by our licensed health care provider. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse will administer the medication or an adult will supervise my child taking his/her own medication unless they have been cleared to self carry/administer as below.

Signature (parent/guardian): ______________________________ Date: ___________
Address: ____
Telephone: Home ______________________ Cell/work: _______________________

B: To be completed by the licensed health care provider/prescriber:

1. Student's Name _______________________________________DOB: ___________
2. Diagnosis: _______________________________________ICD9:_______________
3. Name of medication: ____
4. Prescribed Dosage, Frequency and Route of Administration:___________________
   ____
5. Time to be given in school:____
6. Duration of treatment: ____
7. Possible side effects and adverse reactions (if any):___________________________
   ____
8. Administer morning dose if forgotten at home (with parent permission) Yes or No
   a. AM Dose to be given: ____

☐ I have determined this student is consistent and responsible in taking their own medications (Self-Directed) and in addition, give them permission to self-carry and self-administer this medication. They will be considered independent in medication delivery and need intervention only during emergencies.

Name of Licensed Prescriber and Title (please print): ____________________________
Health care provider's signature: _______________________________ Date: ______
Address: _______________________________________ Phone: _______________
NPI#:____________________________ License#:___________________________