Hermon-DeKalb Central School

709 East DeKalb Road
DeKalb Jct., NY 13630
Phone: 315-347-3442/ Fax: 315-347-3817

Student Name_____ DOB_____ Grade_____

To Be Completed By Health Care Provider

Medication_____ Dose_____ Route_____ Time(s)_____

Diagnosis _____

Comments_____

Prescriber please check if applicable:

☐ I assess this student to be 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 and Title of Licensed Prescriber (Please Print)_____

Signature of Licensed Prescriber: _____ Date: _____

To Be Completed By Parent

I hereby request the school nurse to administer the above medication to my child in accordance with the licensed prescriber's orders and school policy. I will furnish the medication in the original pharmacy container, properly labeled with directions and dosage, or original over-the- counter medication container with my child's name on it.

Parent or guardian signature: _____ Date: _____

In accordance with school policy regarding dispensing medications to students during school hours, please complete and return the above form and medication to the school nurse. No medication, prescription or over-the-counter, may be administered in school without an order from the student's health care provider.