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**PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION
IN SCHOOL AND SCHOOL ACTIVITIES**

A. To be completed by the parent or guardian:

I request that my child _____ DOB _____ receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy*.

PLEASE CHECK ONE:

- _____ I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication, including field trips to my **self directed child**
- _____ I understand that administration of oral, topical or inhalant medications to my **non self-directed child** and injectable medications must remain the responsibility of the school nurse, licensed practical nurse under the direction of a school nurse, physician, or a parent.

Signature (Parent/Guardian): _____

Telephone: Home _____ Work _____ Date _____

B. To be completed by physician:

I request that my patient, as listed below, receive the following medication:

Name of Student _____ DOB _____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment:

Possible Side Effects and Adverse Reactions (if any):

Physician's Signature _____ Date _____

Address _____ Phone _____

- * Medication must be in original pharmacy labeled container with specific orders and names of medication.
- * Medication and refills must be brought to school by parent, guardian or responsible adult.

Plan reviewed with parent(s)/guardian(s):

Parent Signature _____ Date _____