

AUTHORIZATION TO ADMINISTER MEDICATION IN SCHOOL

Genesee Valley Central School  
1 Jaguar Drive  
Belmont, NY 14813

**I. TO BE COMPLETED BY PARENT/GUARDIAN**

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_ Name of School: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Home Address \_\_\_\_\_

Phone numbers during school hours \_\_\_\_\_

I request that the school nurse or designated school official administer the medication as described below by my child's health care provider. **I WILL PERSONALLY DELIVER THE MEDICATION TO THE SCHOOL NURSE, PRINCIPAL, OR DESIGNATED SCHOOL PERSONNEL, IN THE ORIGINAL CONTAINER, OR A DUPLICATE PROFESSIONALLY LABELED BY THE PHARMICIST FOR THIS PURPOSE.** If I cannot deliver the medication myself, I will assign this duty to a responsible adult.

Date: \_\_\_\_\_ Signature \_\_\_\_\_  
Relationship to student \_\_\_\_\_

**This section should be completed only if medically necessary and both parent and prescriber agree:**

Due to the severity of his/her medical condition, this student has been properly instructed in and understands the purpose and appropriate method and frequency of the use of his/her medication and we consider him/her to be responsible. We request the s/he be allowed to carry this medication on his/her person or to keep the medication in his/her locker or P.E. locker. **Please note: this request is contingent on the school nurse's assessment.**

\_\_\_\_\_ Prescriber's initials      \_\_\_\_\_ Parent/Guardian's initials

**II. TO BE COMPLETED BY PRESCRIBER**

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

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Prescribed dosage, route of administration, and frequency \_\_\_\_\_

Time to be taken during school hours \_\_\_\_\_

Duration of treatment \_\_\_\_\_

Side effects (to expect) \_\_\_\_\_  
(to report) \_\_\_\_\_

Prescriber's Name (please print) \_\_\_\_\_ Prescriber's Phone # \_\_\_\_\_  
Fax # \_\_\_\_\_

Prescriber's signature \_\_\_\_\_ Date \_\_\_\_\_

GVCS

Phone: 585-268-7900

Fax: 585-268-7990