Whitesboro Central School District

65 Oriskany Blvd. Suite 1 • Whitesboro, NY 13492 • www.wboro.org

High School: 315.266.3200 | **Middle School:** 315.266.3100 | **Parkway School:** 315.266.3176
Deerfield Elementary: 315.266.3410 | **Hart's Hill Elementary:** 315.266.3430
Marcy Elementary: 315.266.3420 **Westmoreland Road Elementary:** 315.266.3440

Date: ___/___/_____ (MM DD YYYY)

Authorization for Administration of Medication

TO BE COMPLETED BY PARENT-STUDENT INFORMATION:

Last Name:	First Name:	Middle Name:
Date of Birth:	Grade:	Teacher:

I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication, or other designated teacher/ faculty member administer or assist my child with medication during school activities such as field trips, athletic events etc. during the ___/_____ (MM YYYY) school year. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with school staff caring for my child.

Parent/Guardian Signature: ______________________ **Date:** ___/___/_____ (MM DD YYYY)

Home Phone #: (   )   –   **Cell Phone #:** (   )   –   **Work Phone #:** (   )   –

TO BE COMPLETED BY HEALTH CARE PROVIDER:

Diagnosis:		
Medication:		
Dose:	Route:	Frequency/Time(s):
Diagnosis:		
Medication:		
Dose:	Route:	Frequency/Time(s):

Prescriber's Name *(please print)*: ______________________ **Date:** ___/___/_____ (MM DD YYYY)

Prescriber's Signature: ______________________ **Phone #:** (   )   –

HEALTH CARE PROVIDER PERMISSION FOR INDEPENDENT USE AND CARRY:

I attest that this student has demonstrated to me that he or she can self-administer the medication(s) listed safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school/school sponsored activity.

Prescriber's Signature: ______________________ **Date:** ___/___/_____ (MM DD YYYY)

PARENT/GUARDIAN PERMISSION FOR INDEPENDENT USE AND CARRY:

I agree that my child can use their medication effectively and may carry and use this medication independently at any school/school sponsored activity. As the parent/guardian, I accept the responsibility regarding monitoring my child on an ongoing basis to ensure that the child is carrying and taking the medication as ordered.

Parent/Guardian Signature: ______________________ **Date:** ___/___/_____ (MM DD YYYY)