District Name: Jasper-Troupsburg Central School
Contact Person: Michelle Terwilliger, RN
Location: Elementary Building
Address: 908 State Route 36, Troupsburg, NY 14885
Phone #: 607-525-6301 Fax#: 607-525-6309

****

Student's Name: _____ DOB: _____ Gender: _____

Student's Address: _____

_____

Parent/Guardian Name: _____

Phone #(s): _____home _____work _____cell

To Physicians & Parents of Children requiring Medication in School:
In compliance with the rules and regulations of the New York State Education Department, you are requested to complete this form so that required medication may be administered in school to your child.

Name of Drug(s): _____

Generic Name of Drug(s) if possible: _____

Dosage & Frequency: _____

Expected Effect(s): _____

Possible Side Effect(s): _____

Diagnosis **and** ICD9 and ICD 10
_____

Time Duration of Order: _____

Date Order is Effective: _____

Signed Physician's Name: _____ ***Date Signed:*** _____

Physician's Address & Phone #: (pre-printed or office stamp acceptable)

_____ _____
Street Address/PO BOX #

_____
City *State* *Zip Code* *Phone #*

Physician's NPI and License #: _____
NPI # *License #*

Parent Request for School to give Medication:

I hereby request that my child _____ be given the medication above as prescribed by the
Student's Name
Physician.

_____ _____
Parent/Guardian Signature *Date*