

**SOUTH COUNTRY CENTRAL SCHOOL DISTRICT
PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF
MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES**

1) To be completed by the parent or guardian:

I request that my child, _____ DOB _____
GRADE _____ receive the medication as prescribed below by our physician.

The medication is to be personally delivered by me (parent or guardian) in the original labeled pharmacy container stating the specific name of the medication and dispensing orders.

Signature (Parent/Guardian): _____

Telephone: Home _____ Work _____ Date _____

2) 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: _____

*Order may extend to a summer school session if needed Yes No

Possible Side Effects and Adverse Reactions (if any): _____

PLEASE CHECK ONE:

I deem this child to be **self directed** and 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.

I deem this child to be **non self-directed** and understand that administration of oral topical, inhalant and injectable medications must remain the responsibility of the school nurse, licensed practical nurse under the direction of a school nurse, physician, or parent.

Physician's Signature: _____ Date: _____

Address: _____ Phone: _____

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

Parent Signature: _____ Date: _____

*Parent/Guardian must submit written request to School Nurse prior to summer session.