South Buffalo Charter School
Authorization for Administration of Medication

Section A. To be completed by parent or guardian.

I request that my child _____ grade _____, receive the medication as prescribed below by our licensed health care professional. The medication is to be furnished by me in the properly labeled original container from the pharmacy. An **Adult** may only bring in or pick up the medication. I understand that the school nurse will administer the medication or an adult will supervise my **self-directed** child taking his/her own medication. I have read the medication policy and agree to the policy of the school.

_____ _____

Signature (Parent or Guardian) **Printed Name** (Parent or Guardian)

Section B. To be completed by the prescribing licensed health care professional.

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

Name of Student: _____ **Date of Birth:** _____

Diagnosis: _____

Name of Medication: _____

Prescribed Dosage, Frequency and Route of Administration: _____

_____

Time to be taken (During School Hours): _____

Duration of Treatment (20__-20__ School Year): _____

Possible Side Effects/Adverse Reactions (if Any): _____

_____

Other Recommendations: _____

_____

Licensed Prescribing Medial Professional Information (Please print)**:**

Name: _____

Address: _____

Phone: _____ **Fax:** _____

_____ _____

Prescriber's Signature: **Date:**

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Section C. For Inhaler Usage ONLY:

We request that _____ be permitted to carry the prescribed inhaler on his/her person. He/She has been instructed and understands the purpose and appropriate method and frequency of use for the prescribed inhaler. We absolve the school of any responsibility in safeguarding the use of our child's inhaler.

_____ _____

Signature of Parent/Guardian **Signature of Physician)**