SAUQUOIT VALLEY CENTRAL SCHOOL DISTRICT
AUTHORIZATION FOR ADMINISTERING MEDICATION

Sauquoit Valley Central School District requires all students receiving any medication during schools hours, whether prescription or over-the-counter (OTC), to have the following information and meet the following requirements:
(1) this form completed with any additional necessary information from the physician; (2) all medication must be in the original container (either original prescription bottle with proper labeling or manufacturer's container for over-the-counter medication; AND (3) all medication must be delivered by the parent and kept in the nurse's office unless the physician has designated that the student may carry the medication.

Student Name: _____ Grade: _____ D.O.B. _____

PART 1 – TO BE COMPLETED BY THE PHYSICIAN:

Name/Type of medication: _____

Reason for medication (Diagnosis): _____ ICD 10 Code: _____

Form of medication/treatment: (Please check appropriate form of treatment)

Tablet/Capsule___ Liquid___ Inhaler/Nebulizer___ Topical ___ Injection _____ Other_____

Schedule and Dosage to be given at school: _____

Start Date: _____ Stop Date: _____

Restrictions and/or important side effects: None Anticipated ___ If anticipated, please describe: _____

_____

Is this child allergic to any medication? Yes _____ No _____ If yes, what medication(s)? _____

This student may self-carry and self-administer: Yes_____ No_____
(Note that students will only be permitted to self-carry and self-administer acetaminophen, ibuprofen, cough drops, epi-pens, inhalers and Benadryl with parent and physician permission. If required, please send an epi-pen that will not expire during the school year.)

This student may self-carry and self-administer on school-sponsored events: Yes_____ No_____

Physician's Signature: _____ License #: _____ Date: _____

Physician's Name: _____ NPI #: _____ Phone #: _____

PART 2 – TO BE COMPLETED BY THE PARENT/GUARDIAN

I give my permission for my child to receive the above named medication at school. I understand that the medication will be administered to my child by the authorized staff person (i.e. secretary, principal, school nurse, or other designated individual). I understand that the use of self-possessed and self-administered medication will NOT be supervised or monitored by school personnel. I agree that you may contact the physician who prescribed the medication, and I hereby authorize her/him to release to you any information concerning my child's condition and treatment related to the use of this medication. Further, I understand and agree that I will not send medication to school with my child but will deliver it myself.

My child may self-carry and self-administer on school-sponsored events: Yes_____ No _____

_____	_____	_____
Parent/Guardian Print Name	**Parent/Guardian Signature**	**Date**

Home Phone #: _____ Work Phone #: _____