ALLEGANY-LIMESTONE CENTRAL SCHOOL
3131 Five Mile Road •Allegany, NY 14706

District Office
Phone: 716-375-6600
Fax: 716-375-6629

Middle-High School
Ext. 2110/2100
Fax: 716-375-6630

Elementary School
Ext. 4172
Fax: 716-375-6628

Special Education
Ext. 4164
Fax: 716-375-6601

Bus Garage
Ext. 6612
Fax: 716-375-6627

PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

1) To be completed by the parents 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, or we can use the health office stock bottles of medication.

Signature (Parent or Guardian): _____

Phone #: Home _____ Work: _____ Date: _____

2) To be completed by physician

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

• **Acetaminophen** (see chart) orally, every 4 hours as needed for headache, fever, or pain.		
Child's weight-lbs.	Dose - mg	**Parent/Guardian Initials for acetaminophen**
60-95	325	
95 and over	650	
151 and over	May have up to 1000mg	
• **Ibuprofen** (see chart) orally, every 4 hours as needed for headache, fever, or pain.		
Child's weight-lbs.	Dose - mg	**Parent/Guardian Initials for ibuprofen**
48-95	200	
96 and over	400	
• **Rolaids** or **Tums** 1-2 Tabs orally, every 2 hours as needed		
For heart burn or upset stomach		**Parent/Guardian Initials for Rolaids or Tums**

Name of Licensed Prescriber and Title (please print): _____

Prescriber's Signature: _____

Address: _____

Phone #: _____

Date: _____