SCHOOL HEALTH SERVICES
Rochester City School District
131 West Broad Street
Rochester, New York 14614

PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Name of Student: _____ Date of Birth: _____

Diagnosis: _____

Medication: _____ Dose: _____ Route: _____
Ex. 15 mg (not number of units/tabs)

Time during school: _____ (Example: during lunch, before lunch, before gym)
(If you must specify a time, please limit hours to 10:00 am to 1:00 pm, except pm medications.
Parents/guardians should administer before –school or after-school medications).

Intended effects: _____ Restrictions: _____

Conditions under which to administer prn medications: _____

Other medication being taken (ON REVERSE)

Indicate if you have provided additional information as an attachment or on the reverse of this form.

Date: _____ **Prescriber's Signature:** _____ **Tel. Number:** _____

Print Prescriber's Name: _____ **FAX Number:** _____

The spaces below are optional. Please carefully consider the appropriateness of this request.

SELF-ADMINISTRATION AUTHORIZATION

This student has my permission to carry the above named medication on his/her person or to keep same on his/her person or to keep same in his/her locker or physical education locker as I consider him/her responsible. He/She has been fully instructed and understands the purpose, and appropriate method and frequency of the medication administration.

Date: _____ **Physician's signature:** _____

PARENT PERMISSION

We request that this student be permitted to carry the above medication on his/her person or to keep same in his/her locker or Physical Education locker, as we consider him/her responsible. He/She has been instructed in and understands the purpose and appropriate method and frequency of the medication administration. I will participate in the nurse's yearly monitoring.

Date: _____ **Parent/Guardian Signature:** _____

STUDENT ACCEPTANCE OF RESPONSIBILITY

I will carry and/or store my dedication in a responsible manner. I will take it as directed and will not allow others to use the medication. I will visit the nurse once each year for an update on how things are going.

Date: _____ **Student Signature:** _____

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PLEASE RETURN THIS FORM TO:

_____
NAME/TITLE **SCHOOL**

_____
TELEPHONE **FAX:**

This form available on the WEB at http://www.rcsdk12.org on the "Health Services for Parents" link.
SNS/Prescribers Authorization for Admin of Meds