



BEDFORD CENTRAL SCHOOL DISTRICT

632 South Bedford Rd • Bedford, NY 10506

914-241-6000 • www.bcsdny.org

Inspiring and Challenging Our Students

Dr. Robert Glass, *Superintendent of Schools*

Dr. Louis Corsaro, *Medical Director*

GENERAL AUTHORIZATION FOR ADMINISTRATION OF PRESCRIPTION AND NON-PRESCRIPTION MEDICATION IN SCHOOL (Non-epinephrine or Benadryl orders)

New York State Education Law does not permit school personnel to dispense any medication (prescription or non-prescription) without written permission signed by the prescribing healthcare provider and the parent.

TO BE COMPLETED BY THE PHYSICIAN OR PRESCRIBING HEALTH CARE PROVIDER:

***STUDENT'S NAME:** _____ **DOB:** _____ **GRADE:** _____

Name of medication: _____

Dosage: _____ Route: _____ Frequency: _____

Diagnosis/reason: _____

Possible side effects: _____

Desired action: _____ Other

comments: _____

Signature of physician/provider: _____ **Date:** _____

Print name: _____ **Phone #:** _____

TO BE COMPLETED BY THE PARENT/GUARDIAN:

I hereby give my permission to the School Nurse to administer the above medication to my child as specified by the physician/provider.

Signature of parent/guardian: _____ **Date:** _____

Telephone: _____

SELF-CARRY/SELF ADMINISTRATION INSTRUCTIONS:

To be completed by physician/prescriber:

I have instructed the above student in the appropriate use of this medication and the student may be permitted to self-carry and self-administer this medication if approved by the School Nurse.

Signature of physician/prescriber: _____ **Date:** _____

To be completed by the parent/guardian:

When appropriate, I give permission for my child to self-administer the above medication as per the physician/prescriber and the School Nurse.

Parent/Guardian signature: _____ **Date:** _____

To be completed by the School Nurse:

I have assessed the above named student for self-carry and self-administration and approve their doing so.

Signature of School Nurse: _____ **Date:** _____