Duanesburg Central School District

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

A. TO BE COMPLETED BY THE LICENSED HEALTH CARE PRESCRIBER:

I request that my patient, as listed below, receive the following medication:
Name of Student: ______________________________ Date of Birth: ________________
Diagnosis: ____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment: **2017/2018 School Year**

Possible Side Effects and Adverse Reactions (if any): ______________________________

PLEASE CHECK ONE:

- o I deem this child to be **self directed** and understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication, including field trips.
- o I deem this child to be **non self-directed** and understand that administration of oral, topical, inhalant and injectable medications must remain the responsibility of the school nurse, licensed practical nurse under the direction of the school nurse, physician, or parent.

Name of Licensed Prescriber and Title (print): _____________________________________
Address: ____
Phone: ______________________________ Fax: _________________________________
Signature: ____Date ______________

B. TO BE COMPLETED BY THE PARENT OR GUARDIAN

I request that my child _______________________________________ grade __________, receive the medication as prescribed above by our licensed health care prescriber. **The medication is to be furnished by me in the properly labeled original container from the pharmacy, and brought to school by parent, guardian or responsible adult.**

Signature (Parent or Guardian): _____________________________ Date ______________