SOUTHERN CAYUGA CENTRAL SCHOOL
PARENT AND PRESCRIBER'S AUTHORIZATION FOR
ADMINISTRATION OF MEDICATION IN SCHOOL

A. To be completed by the parent or guardian:

I request that my child_____grade_____receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse, or other designated person in the case of the absence of the school nurse will administer the medication.
SIGNATURE (PARENT OR GUARDIAN)_____

ADDRESS_____

TELEPHONE : HOME_____WORK_____ DATE_____

B. 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_____

NAME OF MEDICATION_____

PRESCRIBED DOSAGES, FREQUENCY AND ROUTE OF ADMINISTRATION_____

_____

TIME TO BE TAKEN DURING SCHOOL HOURS_____

DURATION OF TREATMENT_____

POSSIBLE SIDE EFFECTS AND ADVERSE REACTIONS(if any)_____

_____

OTHER RECOMMENDATIONS_____

NAME OF LICENSED PRESCRIBER, TITLE _____

ADDRESS_____

SIGNATURE_____

PHONE_____ DATE_____

C. Self - Medication release for students
Child's Name _____ has been instructed in the proper use of the following:
Medication procedures:_____

_____

Physician signature _____ Parent's signature _____
We request that _____ be permitted to carry the medication on his/her person or to keep in his/her locker or PE locker, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use.