TACONIC HILLS CENTRAL SCHOOL DISTRICT
(518) 325-2855 K-6 Fax (518) 325-2856
(518) 325-2857 7-12 Fax (518) 325-2858

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

A. To be completed by the parent or guardian:

I request that my child ______________________________DOB ____________ receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy*.

Signature(Parent or Guardian): ____

Telephone: Home __________________ Work _________________ Date _____________

B. To be completed by physician:

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

Name of Student ____________________________________ DOB ____________________

Diagnosis: ____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATIO N

Duration of Treatment:

Possible Side Effects and Adverse Reactions (if any):

PLEASE CHECK ONE :

☐ 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.

☐ 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 a school nurse, physician, or parent.

Physician's Signature _______________________________ Date:_______________________

Address: ____ Phone:______________________

* **Medication must be in original pharmacy labeled container with specific orders and name of medication.**

* **Medication and refills must be brought to school by <u>parent, guardian or responsible adult</u>.**

Plan reviewed with parent(s)/guardian(s):

Parent Signature:___________________________________Date:________________________