POTSDAM CENTRAL SCHOOLS

29 Leroy Street
POTSDAM, NY 13676
(315) 265-2000

PARENT AND HEALTHCARE PROVIDER'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. **

Signature (Parent/Guardian): ____

Telephone: Home _______________ Work _______________ Date ___________________________

B. To be completed by the Private Healthcare Provider (the provider may use their own form if desired):

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 ADMINISTRATION

Duration of Treatment____
Possible Side Effects and Adverse Reactions (if any):_____________________________________

PLEASE CHECK ONE:

___ I deem this child to be **nurse dependent** 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.

___ I deem this child to be **supervised** 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 **independent** and understand that the student is permitted to carry the medication on his/her person or to keep same in his/her locker as the student is considered responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use of the medication prescribe

**Medication must be in original pharmacy labeled container with specific orders and name of medication.
**Medication and refills must be brought to school by parent, guardian or responsible adult.

This medication order is valid for the current school year **2016-2017**.

Healthcare Provider's Signature ___________________________ Date:__________ Phone #__________________