Saugerties Central Schools

L.M. CAHILL ELEMENTARY SCHOOL- CALL BOX A-Saugerties, NY 12477

 **Phone (845) 247-6801 Fax Number (845) 246-4302**

## 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 administration** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Duration of Treatment:

Possible Side Effects and Adverse Reactions (if any):

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 parent, guardian or responsible adult.

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

#  Parent Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_