CLINTON CENTRAL SCHOOLS
75 Chenango Avenue
Clinton, NY 13323

Phone: (315)557-4000, **Middle/High School Fax#:** (315)557-2330, -**Elementary Fax#:** (315)557-2331

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

A. To Be Completed By Parent or Guardian:

I request that my child _____ grade _____ receive medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the original container from the pharmacy. I understand that the school nurse will administer the medication or an adult will supervise my child taking his/her own medication.

Signature (Parent or Guardian) _____ Date: _____

B. To Be Completed By The Licensed Health Care Provider:

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

Name of Student: _____ Date of Birth: _____

Diagnosis: _____

Name of Medication: _____

Prescribed Dosage, Frequency, and Route of Administration: _____

_____

Time to be taken during school hours: _____

Duration of Medication Order: _____

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

_____

Other Recommendations: _____

_____

Name of Licensed Prescriber and Title (please print): _____

Prescriber's Signature: _____ Date: _____

Address: _____ Phone: _____

Under certain conditions it may be necessary for a student to carry and self-administer his or her own medication. The decision to allow a student to do this will be made on an individual basis, according to the severity of the health condition, with parental request, a physician's order, and an assessment by the school nurse of the student's ability to carry and administer his/her medication properly. The self-medication release form must be completed.