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**SOUTH GLENS FALLS CENTRAL SCHOOL DISTRICT**

**Parent and Prescriber's Authorization for Medication in School**

**To be completed by the licensed health care prescriber:**

I have prescribed the following medication for: \_\_\_\_\_ GRADE: \_\_\_\_\_

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 treatment: \_\_\_\_\_

Possible side effects and adverse reactions (if any): \_\_\_\_\_

Name of Licensed Prescriber and Title (please print): \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*Provider must Initial appropriate box below\*\*\*

**Administration of Medication by Health Care Provider at School**

I request that my child \_\_\_\_\_ receive medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled container from the pharmacy. I understand that the school nurse or other assigned person will administer the medication.

**Self-Administration of Medication at School or After School Activities**

**(By checking the box you are authorizing this student to carry and use the above medication(s) by him/herself)**

I request that my child \_\_\_\_\_ be permitted to carry the above prescribed medication(s) on his/her person or to keep the above prescribed medication in his/her locker, as I consider him/her responsible. The student has been instructed in and understands the purpose, appropriate method, frequency and use of this medication. The student understands that he/she is responsible and accountable for carrying and using this medication. It is understood that if there is irresponsible behavior or a safety risk, the privilege of carrying his/her medication will be rescinded.

Signature (Parent or Guardian): \_\_\_\_\_

Address: \_\_\_\_\_

Telephone (Home): \_\_\_\_\_