Kristine Orr
Superintendent of Schools
orrk@sgfcsd.org

Bristie Tracy
District Nurse
tracyb@sgfcsd.org

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)

II request that my child _____ be permitted to carry the above medication(s) in the properly labeled container 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that if there is irresponsible behavior or a safety risk, the privilege of carrying his/her medication will be rescinded.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): _____