FORT PLAIN CENTRAL SCHOOL DISTRICT
25 HIGH STREET * FORT PLAIN, NEW YORK 13339-1365
"OUR AIM IS EXCELLENCE" TELEPHONE 518-993-4000

Parent and Prescriber's Authorization for Administration of Medication in School

A. To be completed by parent/guardian:
I request that my child _____, grade _____ receive the medication as prescribed below by our licensed health care Prescriber. The medication is to furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse, trained staff (per supervised student), or whom I have designated, will administer the medication.
Signature (Parent/Guardian) _____
Address _____
Telephone (Home) _____ (Work) _____ Date _____

B. To be completed by the licensed health care prescriber:
I request that my patient, as listed below, receive the following medication.:
Name of Student: _____ Date of Birth: _____
Diagnosis: _____
Name of Medications:
_____
_____
Prescribed Dosage, Frequency and Route of Administration: _____
Time to be taken during the school hours: _____
Duration of Treatment: _____
Possible side effects and adverse reaction (if any): _____
_____
Other recommendations: _____

Please check all that apply:

_____ Supervised Student – can be assisted by trained staff (Student able to identify medication, knows when, how much, and why they take the medication. They know what happens if they don't take it and knows when to refuse the medication).

_____ Nurse Dependent Student

_____ Independent Student – can take (self-administer) their own medication without assistance.

_____ Student takes medication independently in health office (after being handed the medication container by school staff).

_____ Student is permitted to carry and use medication with the required documentation at school and sporting events.

Name of Licensed Prescriber and Title (Please Print) _____

Signature: _____ Date: _____