WAYLAND-COHOCTON CENTRAL SCHOOL
PARENTS & PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL & 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 the physician:

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

Name of Student: _____ DOB_____

Diagnosis: _____ Allergies _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment: _____

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

[ ] I deem this child to be self-directed and understand that the school nurse, or other designated person in the case of absence of the school nurse, will administer the medication, including field trips.
[ ] I deem this child to be non self-directed and understand that administration of oral, topical, inhalant and injectable medications must remain the responsibility of the school nurse, licensed practical nurse under the direction of a school nurse, physician, or parent.
[ ] I deem this child to be able to carry and self-administer one day's worth of medication in the original container on the student's person and not left unattended at any time.

Physician's Signature/Lisc# :_____ Date: _____

Address: _____ Date: _____

- Medication must be in the original pharmacy-labeled container with specific orders and name of medication.
- Medication and refills must be brought to the school by a parent, guardian or responsible adult.
- Medication orders will include the school year, until the end of August of that current school year