2022-2023 School Year

Central Valley Central School District, 111 Frederick St. Ilion, NY 13357

PARENT and PHYSICIAN'S AUTHORIZATION for SKILLED NURSING SERVICES

A. To be completed by 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. * This medication is to be administered during the present school year. It will expire on June 30th each year unless terminated sooner by a doctor's written notice.

I release the school nurse and the Central Valley Central School District, of any liability relative to the administration and/or reaction of the medication on the above named pupil.

☐ My child does not need to take any of the medications listed below during the day while he/she is in attendance at school.

(Please note that this form will need to be completed again if medication and/or dosages change during the year.)

Parent/Guardian Signature _____ Date _____

Telephone: *Home* _____ *Work* _____

B. To be completed by physician:

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

Pupil's Name _____ DOB _____

Diagnosis _____ ICD-10 Code _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment: _____ Does medication require refrigeration? ☐ **YES** ☐ **NO**

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 the 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 or licensed practical nurse under the direction of a school nurse, physician, or parent.

Name of Licensed Prescriber and Title: _____

Please PRINT or STAMP

Address: _____ Phone: _____

NPI# _____ LIC# _____

Signature: _____ **Date**: _____

* Medication must be in original pharmacy-labeled container with specific orders and name of medication.
* Medication and refills must be brought to school by parent, guardian or responsible adult.