CANISTEO GREENWOOD CENTRAL SCHOOL DISTRICT
MEDICATION AUTHORIZATION IN SCHOOL

To Be Completed by Parent

Student: _____ DOB: _____ Grade: _____

I request the school nurse give the medication listed on this plan; or after the nurse determines my child can take their own medication: trained staff may assist my child to take their own medication. I will provide the medication in the **original pharmacy or over the counter container.** This plan will be shared with school staff caring for my child.

Parent/Guardian signature: _____ Phone Number: _____ Date: _____

To Be Completed By Health Care Provider-Valid for 1 Year

Diagnosis **and ICD Code:** _____ Date order is Effective: Start_____ End_____

Name of Drug and Generic name if possible: _____

_____

Dosage and Frequency_____Times: _____

Note: Medications will be given as close to the prescribed time as possible but may be given up to one hour before or after the prescribed time. Please advise if there is a time-specific concern regarding administration.

Expected Effect: _____ Possible Side Effect(s): _____

_____ I assess this student to be **Self-Directed** regarding this medication. I attest that this student has demonstrated to me that they can self-administer the medication(s) listed above safely and effectively, may carry and use this medication (with a delivery device if needed) independently at any school/school sponsored activity. Staff intervention and support is needed only in an emergency

Physician Signature: _____ Physician NPI and License#_____

Physicians Address_____ Phone #_____ Date: _____
(preprinted or office stamp is acceptable above)

Parent/Guardian Permission for Independent Use and Carry

I agree that my child can use their medication effectively and may carry and use this medication independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency.

Parent/Guardian signature: _____ Date: _____