Binghamton City School District

Parent and Physician's Authorization for Administration of Medications in School and School Activities

A. To be completed by the Parent or Guardian:

I request that my child: _____, DOB: _____, receive the medication(s) prescribed below by our Health Care Provider. The medication(s) is/are to be furnished by me in the properly labeled original container from the Pharmacy.*

Signature (Parent or Guardian):_____

Telephone: cell: _____, home: _____, work: _____

B. To be completed by the Health Care Provider:

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

Name of Student: _____, DOB: _____

Diagnosis: _____

Medication	Dosage	Frequency/time to be taken	Route of Administration

___The student has demonstrated proper use of the inhaler/automatic injector device and may carry and self-administer.

___Medication may be omitted for field trips ___Medication MAY NOT be omitted from field trips

___Medication's scheduled time may be adjusted so student may attend field trips

Duration of Treatment/School Year: _____

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

Health Care Provider's Signature: _____, Date: _____

Office Stamp (with phone number):

***** Medication must be in the original pharmacy labeled container with student's name, the name of medication and specific orders (You may ask your pharmacist for a **"double label**" so you can have a labeled container at home)

* Medication and refills must be brought to school by the parent, guardian or responsible adult

***** It is a **violation of school policy** for students to carry any type of medication unless approved by the School Nurse-Teacher or School Nurse. Sending in medication(s) with your child may subject him/her to discipline.

*** All medication must be picked up at the conclusion of the school year. Medications left in the Health Office may be discarded without further notice.**

Please duplicate this form as needed for each child

3/2015