Wayland-Cohocton Central School

PARENT AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF OVER-THE-COUNTER AND PRESCRIPTION MEDICATION IN SCHOOL

Authorization for administration of medication for 2017-2018 school year

A. To be completed by the parent or guardian:

I request that my child _____, grade _____ receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container. I understand the school nurse will administer the medication.

Signature (parent or guardian) _____Date_____

B. To be completed by the licensed health care provider:

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

Name of patient:_____ Date of birth:_____

Address:_____

Diagnosis: _____

Medication/Dose: _____

Frequency/Route/Time:_____

Possible side effects/adverse reactions (if any): _____

Other recommendations: _____

Physician Signature:_____ Date:_____

SELF-MEDICATION RELEASE FORM

We (physician's signature) _____ and

(parent/guardian signature) _____ request

(child's name) _____ be permitted to carry the above listed medication on his/her person, to keep same in his/her locker or P.E. locker, as we consider him/her to be responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use.

NOTE: This form must be completed in full for those students who request permission to carry their own medication on campus or keep this medication in a locker.