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School Nurse Grades Upre K- 6th
776-5728 x 1322

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School Nurse Grades 7th-12th
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PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF

MEDICATION IN SCHOOL AND 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 will be furnished by the parent in the properly labeled original container from the pharmacy, for both prescription and Over the Counter Medication (ie Tylenol, Benadryl, & Cough Drops) with specific orders Signed by the MD. Unless Self-directed, I understand that the school nurse, or other designated person in the absence of the nurse will administer the medication.

Signature(Parent or Guardian)_____

Telephone: _____Home_____Work _____Date _____

B. To be completed by Physician:

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

Medication& Dosage	Time to be taken	Route of administration

Duration of Treatment:_____

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

Physician's Signature _____Date:_____

Address: _____Phone:_____

Port Byron Central School District has my permission to contact my Child's Doctor and My Child's Doctor has permission to send back needed information and or forms

Doctor's Name_____Number_____

Parent's Signature_____Date_____

Port Byron Central School District

(315) 776-5728 x 1321 FAX (315) 776-5373

Self-Medication Release Form

Date:_____

Student's Name:_____ has been instructed in the proper use of the following medication procedures:

_____

We (*Physician's signature)*_____and

(*Parent/guardian's signature)*_____

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

I (School Nurse)_____have observed

(Student's name)_____on (Date)_____

& DO / DO NOT feel that he/she is properly administering his/her medication as prescribed, can name the medication, describe what it look like, understands the purpose, the appropriate method and frequency of use.

If School Nurse has concerns:

Parents notified_____ (Date)

Physician notified_____(Date)

Note: This form must be completed IN ADDITION to routine district medication form for those students that will be Self-Medicating.