



Duanesburg Central School District

Central Office
133 School Drive
Delanson, NY 12053
518-895-2279
Fax 895-2626

Elementary School
165 Chadwick Road
Delanson, NY 102053
518-895-2580
Fax 895-2957

Jr. Sr. High School
163 School Drive
Delanson, NY 12053
518-895-2355
Fax 895-2028

PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

A. TO BE COMPLETED BY THE LICENSED HEALTH CARE PRESCRIBER:

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

Name of Student: _____ Date of Birth: _____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment: **2011-2012 School Year**

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

The student named above has been instructed in the proper use of the medication noted and understands the purpose and appropriate method and frequency of use. If checked "Student may carry medication", we request that the student be permitted to carry the medication on his/her person, keep same in his/her locker, PE locker, during field trips and/or sporting events, as we consider him/her responsible.

- Keep medication in nurse's office
- Student may self/carry self administer medication.
- May carry water bottle during school

Name of Licensed Prescriber and Title (print): _____

Address: _____

Phone: _____ Fax: _____

Signature: _____ Date _____

B. TO BE COMPLETED BY THE PARENT OR GUARDIAN

I request that my child _____ grade _____, receive the medication as prescribed above by our licensed health care prescriber. **The medication is to be furnished by me in the properly labeled original container from the pharmacy, and brought to school by parent, guardian or responsible adult.** I understand that the school nurse will administer the medication unless indicated as self-carry/self-administer above by the physician.

Signature (Parent or Guardian): _____ Date _____