BROOME•TIOGA boces
Enriching Lives Through Education

Authorization for Medication Administration at School

To be completed By Parent/Guardian:

I request that my child _____ DOB _____. Receive the medication as prescribed below by our physician. (The medication is to be furnished in the original, properly labeled container from the pharmacy).

PLEASE CHECK ONE:

_____ I understand that the school nurse, or other designated person in the nurse's absence, will assist with administration of the medication, including field trips, to my **self-directed child**.

_____ I understand that administration of oral, topical, inhalant or injectable medications to my **non-self-directed child** must remain the responsibility of the school nurse or licensed practical nurse under the direction of a school nurse, physician or parent.

Signature (Parent/Guardian): _____ Date: _____

Telephone: (Home) _____ (Work) _____ (Cell) _____

***Medication must be in original pharmacy labeled container with specific orders and name of medication. Medication and refills must be brought to school by a parent, guardian or responsible adult.**

To be completed by Physician:

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

Student Name: _____ DOB: _____

Diagnosis: _____

MEDICATION	INDICATION	POSSIBLE ADVERSE EFFECTS	DOSE	FREQUENCY/TIME	DURATION	ROUTE

Physician's Signature: _____ Date: _____

Physician's Name (Printed): _____

Address: _____

Phone: _____