CENTRAL SQUARE CENTRAL SCHOOL DISTRICT

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

Parent and Prescriber's Authorization for Administration of Medication:

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 from the pharmacy. I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication.

Signature (Parent or Guardian): _____

Address: _____

Telephone: (Home) _____ (Work) _____ Date _____

B. 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: _____

Name of Medication: _____

Prescribed Dosage, Frequency and Route of Administration:

_____

Time to Be Taken During School Hours: _____

Duration of Treatment: _____

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

_____

Other Recommendations: _____

_____

Name of Licensed Prescriber and Title (please print): _____

Prescriber's

Signature: _____ Date: _____

Address: _____ Phone: _____

SELF-MEDICATION RELEASE FORM

Child's Name:_____ Date:_____

Has been instructed in the proper use of the following medication procedures:_____

_____

We (Physician's signature):_____

And (Parent or Guardian signature):_____

Request that (Child's name):_____be permitted to carry the medication on his/her person or to keep same in his/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.