POTSDAM CENTRAL SCHOOLS

29 Leroy Street
Potsdam, New York 13676
315-265-2000

PARENT AND HEALTHCARE PROVIDER'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.

Signature (Parent/Guardian): _____ Date:_____

B. To be completed by the Private Healthcare Provider (the provider may use their own form if desired)**:**

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

Name of Student: _____DOB : _____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Possible Side Effects and Adverse Reactions (if any):

This medication order is valid for the current school year_____.

PLEASE CHECK ONE:

- I deem this child to be **nurse dependent** and understand that administration of oral, topical, inhalant and injectable medications must remain the responsibility of the school nurse, licensed practical nurse under the direction of a school nurse, physician or parent.

___I deem this child to be **supervised** and understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication, including field trips.

_I deem this child to be **independent** and understand that the student is permitted to carry the medication on his/her person or to keep same in his/her locker as the student is considered responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use of the medication prescribed.

***All controlled substances must be locked in the health office regardless of whether or not the student is deemed independent.**
** If a student is deemed independent by their healthcare provider and their parent/guardian to carry an epinephrine auto-injector, a respiratory rescue medication or insulin/glucagon/diabetes supplies, the ***PROVIDER ATTESTATION AND PARENT PERMISSIONS REQUIRED FOR INDEPENDENT MEDICATION CARRY AND USE* **form must also be completed.**

Healthcare Provider's Signature: _____ Date:_____
Phone #:_____