Green Island Union Free School District

171 Hudson Avenue
Green Island, New York 12183

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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. This medication is to be furnished by me in the properly labeled original container from the pharmacy.

Print (Parent or Guardian):_____ Signature _____
Telephone Home_____ Work_____ Date_____

B. TO BE COMPLETED BY PHYSCIAN:

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

Duration of Treatment:_____
Possible side effects and adverse reactions (if any):_____
_____

PLEASE CHECK ONE:

☐ I deem this child to be **self-directed** 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 **non self-directed** 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.

Physician's Signature:_____ Date:_____

Address:_____ Phone:_____

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

Plan reviewed with parent/guardian(s):

Parent signature:_____ Date:_____