CLARENCE CENTRAL SCHOOL DISTRICT

Authorization for Administration of Medication in School

To be completed by the Parent/Guardian each school year.:

Student Name _____ Grade_____ Date of Birth_____

- I request that my child 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.
- I understand medication will only be held during the school year and must be picked up in June.

X_____ _____ _____
Signature (Parent/Guardian) Please Print Name Date

TO BE COMPLETED BY THE LICENSED PRESCRIBER EACH SCHOOL YEAR:

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

Medication: _____ Diagnosis: _____

Dose: _____ Frequency: _____ Time: _____ Route: _____

Duration of Treatment: ❑Current School year ❑_____

X_____ _____
Prescriber's Signature Name of Licensed Prescriber & Title (please print name)

_____ _____
Practice Name Date

PROVIDER ATTESTATION for self-carry:

I attest that this student has demonstrated to me that he/she can self-administer the medication(s) listed below safely and effectively and may carry and use this medication independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency. This order applies only to the diagnosis and medication checked below:

- ❑ *Allergy* and requires Epinephrine Auto-injector
- ❑ *Asthma* or respiratory condition and requires Inhaled Respiratory Rescue Medication
- ❑ *Diabetes* and requires Insulin/Glucagon/Diabetes Supplies

X_____ AND X _____
Physician's Signature Parent's Signature

School Nurse: _____ Phone: _____ Confidential Fax _____