Bainbridge-Guilford Central School District

Parent/Guardian Authorization to Administer Medication at School.

A. TO BE COMPLETED BY THE PARENT OR GUARDIAN:

I request that my child, _____, grade_____, receive medication as prescribed below by our licensed health care provider. The medication is to be furnished by me in the properly labeled original container from the pharmacy. The label must contain directions and dosage, or original over- the- counter (OTC) container with my child's name on it. I understand the School Nurse or trained staff member, in the event the School Nurse is unavailable, will administer the medication.

I understand that the teacher or other school personnel will administer only the medication described below. If the prescription is changed, a new form for parental consent and a new physician's order must be completed before the school staff can administer the new medication.

Signature_____

B. HEALTHCARE PROVIDER AUTHORIZATION: TO BE COMPLTED BY A LICENSED HEALTH CARE PROVIDER:

Name of Student:_____ Date of Birth_____

Diagnosis:_____

Name of Medication:_____

Dose, Frequency & Route of Administration:_____

Time to be taken at School:_____

Possible Side Effects:_____

Name of HealthCare Provider:_____

Signature:_____Date:_____

Address:_____Phone: _____

*** A separate form needs to be filled out for each additional medication***

Medications, even OTC, <u>WILL NOT</u> be administered without this form completed