Susquehanna Valley School District

High School	**Health Office: 607-775-9119**	**Fax: 607-775-7509**
RTS Middle School	**Health Office: 607-775-9136**	**Fax: 607-775-7508**
Brookside Elementary	**Health Office: 607-669-4201**	**Fax: 607-775-7502**
Donnelly Elementary	**Health Office: 607-775-9108**	**Fax: 607-775-7507**

PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

A. To be completed by physician:

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

Name of Student: _____ DOB: _____

Diagnosis: _____ _____ICD 10:_____

MEDICATION	DOSAGE	FREQUENCY	ROUTE	INDICATION	START/END DATES

NURSING TREATMENT	FREQUENCY	START DATE	END DATE

Duration of Treatment : _____

Possible Side Effects and Adverse Reactions (if any):

_____

_____

Health Care Provider Permission for Independent Use and Carry ☐ YES ☐ NO

I attest that this student has demonstrated to me that they can self-administer the medication(s) listed safely and effectively, and may carry and use this medication(with a delivery device if needed) independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency.

PLEASE FILL IN ENTIRE BELOW SECTION PRIOR TO RETURN

Physician's Name (print): _____

Signature: _____ Date: _____

Address: _____ Phone: _____

License #: _____NPI # _____ Professional's Title: _____

B.. To be completed by the parent or guardian:

I request that my child _____ DOB: _____ Grade: _____ receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy*.

Signature (Parent or Guardian): _____

Telephone: Home: _____ Daytime: _____ Date: _____

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