

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: 607-300-3215
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 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: _____

B. 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):

Student may carry /administer Own Medication YES NO
PLEASE FILL IN ENTIRE BELOW SECTION PRIOR TO RETURN

Physician's Name (print): _____

Signature: _____ Date: _____

Address: _____ Phone: _____

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

- * 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.