## 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 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.**