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.**