Williamsville Central Schools

Encouraging - Nurturing - Challenging

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

Medication includes both non-prescription and prescription drugs

A. To be completed by the Parent or Guardian: Student Name: _____

School _____ Grade/Homeroom _____

I request that my child _____ receive the medication as prescribed below by our licensed health care prescriber. The medication should be furnished by an adult, in the properly labeled original container from the pharmacy*. I understand that the school nurse will administer the medication or if my child is deemed self-directed, a trained adult will supervise my child taking his/her own medication.

In some situations, a child with a life threatening medical condition may have emergency medications that can be self-carried / self-administered (such as an inhaler, epi-pen, insulin, glucose gel). If your child is deemed able to self-carry / self administer an emergency medication, please contact your school nurse for direction in this process. All students who are deemed able to self-administer & carry their medication must have approval by the school nurse after an order and consent has been received.

Signature (Parent or Guardian): _____

Telephone: Home _____ Work _____ Other _____ Date _____

B. To be completed (or script/information attached to this form) by Private Healthcare Provider:

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

Name of Student _____ DOB _____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE & SIDE EFFECTS IN WHICH TO MONITOR / REPORT TO PARENT/PROVIDER

Healthcare Provider's Signature _____ Date: _____

Address: _____ Phone: _____

C. Additional signatures for self administration / self carry request:

Based upon the child's level of understanding of his/her life threatening medical condition and ability to manage the medication(s): _____,

it has been determined that a request for self- administration / self carry can be considered. I understand this must have additional approval by the school nurse.

_____ (Signature of Medical Provider)

_____ (Signature of Parent)

* *Medication must be in original pharmacy labeled container*

* *Medication and refills should be brought to school by parent, guardian or responsible adult*

(11/09)