CHEEKTOWAGA CENTRAL SCHOOL DISTRICT

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

TO BE COMPLETED BY THE PARENT OR GUARDIAN

I request that my child _____, grade _____ receive the medication as prescribed below by our licensed health care provider. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand the school nurse, or other assigned person will administer the medication.

SIGNATURE (Parent or Guardian): _____

ADDRESS: _____

TELEPHONE NUMBER: Home/Cell: _____ Work: _____

TO BE COMPLETED BY THE LICENSED HEALTH CARE PRESCRIBER:

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

Name of Student: _____ Date of Birth _____

Diagnosis: _____

Name of Medication: _____

Prescribed Dosage, Frequency and Route of Administration: _____

Student is permitted to carry inhaler, epi pen (Self Carry): Yes _____ No _____

Student is permitted to use the school's stock of albuterol in the event their own albuterol prescription is empty: Yes _____ No _____

Time to be taken during school hours: _____

Duration of Treatment: _____

Possible Side Effect and Adverse Reactions (if any): _____

Other Recommendations: _____

Name of Licensed Provider and Title (please print): _____

Provider's Signature: _____ Date: _____

Address: _____ Phone: _____