

NORTH ROSE-WOLCOTT CENTRAL SCHOOL DISTRICT AUTHORIZATION FOR ADMINISTERING MEDICATION

The North Rose-Wolcott Central School District requires all students receiving any medication during schools hours, whether prescription, over-the-counter or homeopathic, to have the following information and meet the following requirements: (1) this form completed with any additional necessary information from the physician; (2) ALL medication must be in the **original prescription bottle** and properly labeled; (3) prescribed over the counter medication must be in the manufacturer's container; (4) ALL medication must be provided by the parent and kept in the school office unless the physician has designated that the student may carry the medication; and (5) parents must deliver all medication to school unless the physician's order specifies that the student is to carry the medication.

School _____
Student _____ Grade _____ D.O.B. _____

PHYSICIAN'S STATEMENT – To be completed by physician:

Name/Type of medication: _____

Reason for medication (Diagnosis) _____ ICD 10 Code: _____

Form of medication/treatment: (Please check appropriate form of treatment)

Tablet/Capsule ___ Liquid ___ Inhaler/Nebulizer ___ Topical ___ Injection ___ Other _____

Schedule and Dosage to be given at school: _____

Start Date: _____ Stop Date: _____

Restrictions and/or important side effects: None Anticipated ___ If anticipated, please describe _____

Is this child allergic to any medication: Yes ___ No ___ If yes, what medication? _____

This student may carry their inhaler and is capable of self-administration: Yes ___ No ___
(Students are not allowed to possess controlled substances at school.)

This student may self-carry and self-administer on school-sponsored events: Yes ___ No ___

Physician's Signature _____ License #: _____ Date _____

Address _____ NPI #: _____ Phone # _____

If required, please send an EPIPEN that will not expire during the school year.

PARENT/GUARDIAN PERMISSION

School policy prohibits students from possessing any type of medication in school, including over-the-counter medication unless prescribed by a physician.

I give my permission for my child to receive the above named medication at school. I understand that the medication will be administered to my child by the authorized staff person (i.e. secretary, principal, school nurse, or other designated individual). *I understand that the use of self possessed and self administered medication (i.e. inhalers) will NOT be supervised or monitored by school personnel.* I agree that you may contact the physician who prescribed the medication and I hereby authorize her/him to release to you any information concerning my child's condition and treatment related to the use of this medication. Further, I understand and agree that I will not send medication to school with my child but will deliver it myself.

Parent/Guardian Print Name

Parent/Guardian Signature

Date

My child may self-carry and self-administer on school-sponsored events: Yes ___ No ___

Home Address _____

Home Phone # _____

Work Phone # _____