CAMPBELL-SAVONA SCHOOL

7885 County Rt. 125, Campbell, New York 14821
607-527-9800 x 1411
Fax 607-527-9863

ADMINISTRATION OF MEDICATION IN SCHOOL

A. To be completed by the parent or guardian:

I request that my child _____ grade_____ receive the medication as prescribed below by our licensed heath care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication.

Signature (Parent or Guardian):_____

Telephone: Home_____Work_____Date_____

B. To be completed by the licensed health care prescriber:

I request 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:

Time to Be Taken During School Hours:_____
Duration of Treatment:_____
Possible Side Effects and Adverse Reactions (if any):_____

Name of Licensed Prescriber and Title (please print):_____
Prescriber's Signature:_____Date:_____
Address:_____Phone:_____

C. SELF-MEDICATION RELEASE FORM –Emergency Medications Only (i.e. inhalers, epipen, etc.)

Child's Name_____
Has been instructed in the proper use of the above medication.

We (Physician's signature)_____Date:_____
And (Parent or Guardian's signature)_____Date:_____
Request that (Child's Name)_____
Be permitted to carry the medication on his/her person or to keep same in his/her locker or P.E. locker, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use.