TIOGA CENTRAL SCHOOL DISTRICT
TIOGA CENTER NY
Telephone (607) 687-8006 Fax (607)687-8010

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 _____ 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 _____ Work _____ Date _____

B. To be completed by physician:

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 OF ADMINISTRATION

Duration of Treatment:

Possible Side Effects and Adverse Reactions (if any):

PLEASE CHECK ONE :

- ☐ I deem this child to be **self directed** and understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication, including field trips.
- ☐ I deem this child to be **non self-directed** and understand that administration of oral, topical, inhalant and injectable medications must remain the responsibility of the school nurse, licensed practical nurse under the direction of a school nurse, physician, or parent.

Physician's Signature _____ Date:_____

Address: _____ Phone:_____

* Medication must be in original pharmacy labeled container with specific orders and name of medication.

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