SOUTH COLONIE CENTRAL SCHOOLS

PHONE: 459-1333 EXT. 4450 FAX: 459-0285

PARENTS AND PRESCRIBERS AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

Student's Name: _____ D.O.B.: _____ Grade/Section: ____ School Year: _____

Medication: _____

Dosage: _____

Frequency: _____

For Treatment of: _____

Time to be taken during school: _____

Medication: _____

Dosage: _____

Frequency: _____

For Treatment of: _____

Time to be taken during school: _____

SELF-MEDICATION RELEASE FORM

☐ This child has been instructed in the proper use of the following medications:

_____ _____

and is permitted to carry the medication(s) on his/her person or keep same in his/her locker or P.E. locker (**with exception of any controlled substance**). This includes field trips and sports events. He/she has been instructed in and understands the purpose and appropriate method and frequency of use.

☐ This child is considered self-directed for the purposes of **field trips**. During said activity, it will be recommended that the medication be held by chaperone/coach or teacher until it is needed.

N.B. Any student found sharing their medication with any other person will have self-directed permission rescinded immediately.

***ALL orders must be renewed at the beginning of each school year per NYS Law.**

Physician's Signature: _____ Printed Name: _____ Date: _____

I request that my child receive the medication as prescribed above by our physician. 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, including for field trips.

Parent Signature: _____ Printed Name: _____ Date: _____