BATAVIA CITY SCHOOL DISTRICT

PARENT AND HEALTH CARE PROVIDER'S AUTHORIZATION FORM
ADMINISTRATION OF MEDICATION (PRESCRIBED OR OVER-THE-COUNTER) IN SCHOOL

A. **TO BE COMPLETED BY THE PARENT/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 PHARMCY. I UNDERSTAND THAT THE SCHOOL NURSE, OR OTHER DESIGNATED PERSON IN THE CASE OF THE ABSENCE OF THE SCHOOL NURSE, WILL ADMINISTER THE MEDICATION. I GIVE PERMISSION FOR THE SCHOOLNURSE TO SHARE INFORMATION WITH STAFF ON A "NEED TO KNOW" BASIS FOR MY CHILD'S HEALTH SAFETY.

_____ _____
Signature of Parent/Guardian Date

B. **TO BE COMPLETED BY THE LICENSED HEALTH CARE PROVIDER:**

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): _____

THIS STUDENT IS CAPABLE OF SELF-ADMINISTERING THIS MEDICATION WITH SUPERVISION:
☐ YES ☐ NO

THIS STUDENT IS CAPABLE OF SELF-ADMINISTERING THIS MEDICATION UNSUPERVISED:
☐ YES ☐ NO

THIS MEDICATION IS NECESSARY FOR FIELD TRIPS: ☐ YES ☐ NO

OTHER RECOMMENDATIONS: _____

_____

_____ _____
LICENSED HEALTH CARE PROVIDER TITLE

_____ _____
PROVIDER'S SIGNATURE DATE

_____ _____
ADDRESS PHONE