SOUTH COLONIE CENTRAL SCHOOLS

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 medication(s):

  _____ _____

  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 **not** deemed self-directed and **cannot** carry or self-administer their medication at any time.*****

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

***For FIELD TRIPS** – A parent must accompany a child who is not self-directed. If a parent cannot attend, they can designate someone who is not an employee of South Colonie School District. If there is no one available, the school will make every attempt to send a nurse. If a nurse cannot attend, the field trip must be cancelled.

N.B.: Any student found sharing their medication with any other person will have self-directed permission rescinded immediately.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: _____ **Date:** _____ **Printed Name:** _____

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 field trips.

Parent Signature: _____ **Date:** _____

FOR SCHOOL USE ONLY

Nurse: _____/_____

(Initials) (Signature) (Initials) (Signature)

_____/_____

(Initials) (Signature) (Initials) (Signature)

MED COUNT

Date Rec'd	No. Rec'd/Med	Rec'd From	Nurse Signature

Students Schedule attached: