BARKER CENTRAL SCHOOL
HEALTH OFFICE
Phone: (716) 795-9322
Fax: (716) 795-3678

Parent & Physician Authorization Administration of Medication

A. To be completed by the parent or Guardian:

I Request that my child, ____

DOB ________________________ receive the medication as prescribed below by our physician.

* Medications must be in their **original container**. This includes over the counter preparations.
* Medication and refills must be **delivered directly** to the school nurse by the parent/guardian.

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:
- o Entire school year Start date: _________________ Stop Date: _________________
- o Order may remain for the duration of summer school

Possible Side Effects & Adverse Reactions (if any) ____

o **I deem this child to be self-directed: able to carry and administer medication independently, including during field trips or school sponsored events. He/she has been instructed in and understands the purpose and appropriate method and frequency of use.**

(School nurse will also assess student's ability for self-directed medication administration.)

Physician's Signature ____ Date: ____________________

Address: ____ Phone: ___________________