Tri-Valley Central School District

34 Moore Hill Road • Grahamsville, New York 12740

Phone (845) 985-2296 Michael Williams, Superintendent

Parent and Physician's Authorization for Administration of Medication in School and School Activities

A. **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 ADMINSTRATION

Possible Side Effects and Adverse Reactions (if any): _____

_____

PLEASE CHECK ONE:

☐ **Self-directed student:** means that the student can: Identify the correct medicine, identify the purpose of the medication, determine dosage being administered, describe what will happen if the medication is not taken, and able to refuse the medication if the student has any concerns about its appropriateness.

☐ **Non self-directed student**: means 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.

I assess this student to be self-directed ☐ Yes ☐ No
Student may self-carry and self-administer medication ☐ Yes ☐ No

NOTE: The school nurse will also assess self-direction for the school setting. Parent should send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given at home.

Physician's Signature: _____ Date: _____

Address: _____ Phone: _____

- All medications for K-5 are held in the nurse's office, during the field trip, the teacher carries the medication.
- Medication must be in the original pharmacy labeled container with specific orders and the name of the medication.
- Medication and refills must be brought to school by parent, guardian or responsible adult.

B: To be completed by Parent/Guardian:
Your signature below indicates your approval for your child to be self-directing and able to follow the medication order(s) listed above while in school and/or on school trips.

Parent Signature: _____ Date: _____

School Nurse: _____ Date: _____

CC: Nurse