Eldred Central School District

George Ross Mackenzie Elementary (PreK-6)
1045 PROCTOR ROAD PO Box 249
GLEN SPEY, NY 12737
Phone: 845-456-1100, Ext. 5003
Main Office Fax: 845-856-8579

Eldred Central School (grades 7-12)
600 Rt 55, P O Box 249
Eldred, NY 12732
Phone: 845-456-1100, Ext. 5131
Nurse's Fax: 845-557-3672

PARENT AND PRESCRIBER AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

A. To be fully completed by the licensed healthcare professional.

I request that my patient, as listed below, receive the following medication(s):

NAME OF STUDENT: _____ DOB: _____
DIAGNOSIS: _____
NAME OF PRESCRIBED MEDICATION: _____
DOSAGE: _____ FREQUENCY: _____ ROUTE: _____
POSSIBLE SIDE EFFECTS OR REACTIONS (IF ANY): _____
OTHER RECOMMENDATIONS: _____

PLEASE CHECK YES OR NO BELOW:

□ NO □ YES May this medication be self-administered? Self-administered medication applies only to inhalers and EpiPens. If YES, the student should be permitted to carry this medication on his/her person, as we consider him/her to be responsible. He/she has been instructed on the use of and understands the purpose, frequency and side effects of this medication.

PRESCRIBER'S NAME (please print): _____ TITLE: _____

PRESCRIBER'S SIGNATURE: _____ Date: _____

Address: _____

Telephone: _____

B. To be fully completed by parent or 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 pharmacy. I understand that the school nurse, or the designated person in the case of absence of the school nurse, will administer the medication. I do hereby release, discharge and hold harmless the Eldred Central School from any and all liability and claim whatsoever for administration of the medication to my child should they develop any allergic reaction from the medication. □ I do □ I do not want this medication administered on half days of school. I am aware of my doctor's recommendations, and fully support them.

NOTE: THE VERY FIRST DOSE OF THIS MEDICATION FOR CURRENT CONDITION/ILLNESS MAY NOT BE GIVEN AT SCHOOL.

Signature

(Parent/Guardian): _____

Address: _____

Telephone: Home: _____ Work: _____ Date: _____