CAMDEN CENTRAL SCHOOL DISTRICT

Parent and Prescriber's Authorization for Administration of Medication in School

TO BE COMPLETED BY PARENT OR GUARDIAN:

I request that my child _____, in grade _____, receive the medication as prescribed by our licensed health care provider. The medication is to be supplied by me in the properly labeled, original container from the pharmacy. All and any medication should be transported to school by an adult only. I understand that the school nurse or other designated person, (if the school nurse is unavailable) will administer the medication.

Parent/Guardian Signature: _____ Date _____

Address: _____

Telephone: Home _____ Work _____ Cell _____

ORDERS MUST BE RENEWED EVERY SCHOOL YEAR.
These orders are valid through the current school year and extended into summer school.

TO BE COMPLETED BY THE LICENSED HEALTH CARE PRESCRIBER:

I request that my patient, as listed below, receive the following medication.

Name of Student: _____ DOB: _____

Diagnosis: _____ 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): _____

Other Recommendations: _____

Name of Licensed Prescriber and Title (Please print): _____

Prescriber's Signature: _____ Date: _____

Address: _____ Phone: _____

TO BE COMPLETED BY PARENT/GUARDIAN AND THE LICENSED HEALTH CARE PRESCRIBER:
SELF MEDICATION RELEASE

Your child has been instructed in the proper use of the following medication procedures: _____

_____

Possible side effects and adverse reactions (if any): _____

We: _____ and _____
Prescriber's signature **Parent/Guardian signature**

Request that _____ be permitted to carry the medication on his/her person or to keep same in his/her locker or P.E. locker, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use.

_____
Student signature

Revised 12/14