BEV MARTIN, **RN**
Head of Health Services
(315) 287-1902

GOUVERNEUR CENTRAL SCHOOL DISTRICT

HEALTH OFFICE
133 East Barney Street
Gouverneur, New York 13642
FAX: (315) 287-5517

PARENT AND HCP'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION/TREATMENTS IN SCHOOL AND AT SCHOOL ACTIVITIES

Name of Provider: _____

License or NPI #: _____

Address: _____

Phone #: _____

Student's Name:_____

Diagnosis:_____

Medication or Treatment:_____

Dosage, frequency and route:_____

Side effects to monitor for (if any):_____

Start Date:_____ Stop Date:_____

*Student will need medication on field trips and/or after school activities: Yes No

*Student may self carry and self administer medications: Yes No (if answer is yes, skip next question)

*Student may self administer with adult supervision. (ie: teacher/coach): Yes No

I request that my child receive the medication or treatment as prescribed above. The medication will be brought to the school nurse by me in a properly labeled container from the pharmacy.

I give permission to the school nurse to share with the appropriate school personnel information relative to the prescribed medication administration, e.g. adverse side effects, as the nurse determines necessary for my child's health and safety. Yes_____ No_____ Any restriction on release?_____

_____ _____
Parent/Guardian signature date

_____ _____
Physician's signature date

(Please note: I understand that the medicine will be destroyed if it is not picked up on the last day of school)