Favetteville-Manlius School District

PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

A. To be completed by the parent or guardian:

I request that my child _____ DOB ____ receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacv*.

Parent/Guardian Signature:_____

Home Phone: Work Phone: Date:

* Medication must be in the original pharmacy-labeled container with specific orders and name of the medication. Medication and refills must be brought to school by a parent, guardian or responsible adult.

B. To be completed by physician:

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

Student name:	DOB:	

Diagnosis:

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Statent is ben an ever and may ben carry and ben administer incarcation in 125 170	Student is self-directed and may self-carry and self-administer medication:	YES	NO
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Physician's Signature: Date:

Address: Phone:

Plan reviewed with parent(s)/guardian(s):

Parent/Guardian Signature:	
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