Fayetteville-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 pharmacy*.

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

Student is self-directed and may self-carry and self-administer medication: YES NO

Physician's Signature:_____**Date:** _____

Address:_____**Phone:**_____

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

Parent/Guardian Signature:_____**Date:** _____