Northmor Local School District

Authorization for administration of prescription and non-prescription medicine at Northmor Schools by school personnel

Physician/Prescribing Health Care Provider

Patient's Name_____Date_____DOB_____

Patient's Address_____Grade_____

Name of Medication_____

Dosage _____Time(s) for Administration _____Rate_____

Specific Instructions for Administration_____

Specific Instructions on Storage _____

Possible Side Effects_____

Side effects that need to be reported to physician_____

Telephone number where physician can be reached in an emergency_____

Is this a controlled drug? _____Yes _____No

I understand and agree that this request and the standing orders for the administration of medication by school personnel will remain in effect until the _____day of _____, for one school year or unless sooner revoked in writing by either the parents/guardian of the child or myself.

_____ _____

Physician's Signature Date

Parent/Guardian Authorization

I request that my child, named above, be permitted to receive from school personnel, the above ordered medication. I take responsibility for this permission. I understand that the medication must be in the original pharmacy container, labeled with the name of the student, prescribing health care provider, date of original prescription; strength and dose of medication; and directions for use. No more than a 45 school day supply of medication will be kept at school. This medication will be destroyed unless picked up within one week after the school year or end of the medical order.

_____ _____ _____

Parent Signature Date Student Signature

_____

Parent Telephone Number