

# Au Sable Valley Central School District

## Health Office Contacts:

**Au Sable Valley Middle High**    Phone: 834-2820    Fax: 834-5325  
**Au Sable Forks Primary**        Phone: 647-5502    Fax: 647-8471  
**Keeseville Elementary**        Phone: 834-2839    Fax: 834-2857

### Authorization for Administration of Medication in School

The New York State Department of Education and AVCS require that all students who **need** medication **during school hours** provide the following:

- 1. Written orders from the physician directing the nurse to give medication.**
- 2. Written consent signed by the parent/guardian.**
- 3. Medication in the original bottle delivered by the parent/guardian.**

#### **Part A. To be completed by parent/guardian**

I request that my child \_\_\_\_\_, grade \_\_\_\_\_, be given the medication as prescribed below by our licensed health care provider. **The medication will be delivered to school by me in the properly labeled, original container from the pharmacy.** I understand that the school nurse, or other designated person in case of the absence of the school nurse, will administer the medication.

Parent/Guardian Signature **X** \_\_\_\_\_ Date \_\_\_\_\_  
Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Emergency Contact \_\_\_\_\_

#### **Part B. To be completed by licensed health care provider**

I request that my patient receive the following medication:

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

Diagnosis \_\_\_\_\_

Name of 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 provider \_\_\_\_\_ Title \_\_\_\_\_

Provider's Signature **X** \_\_\_\_\_ Date \_\_\_\_\_

Address: \_\_\_\_\_ Phone \_\_\_\_\_