New City School
Administration of Medication in the School

Student Name: _____
Birthdate: _____

Please complete the information below for Physician Order/Authorization and Parent/Guardian Request for Administration of Medication by School Personnel OR Authorization for Self-Carry/Self-Administration. This form MUST be completed for both prescription and over-the-counter medications.

For Medication Administered in the School by Designated Staff

Medication: _____ Dose;_____
Time of Administration: _____ Frequency:_____
Missed morning dose of this medication, may be given at school with: Parent/Guardian permission _____ (initial) or student request _____(initial)
For treatment of: _____ Possible side effects: _____ Last date to be given:_____

Medication allergies: _____
Print Physician Name: _____ Phone:_____
Physician Signature: _____ Date:_____
I, the parent/guardian, request this medication be given as prescribed. I release school personnel from any liability in the administration of this medication at school. I understand that I am responsible for communications with the health care providers ordering this medication. **I understand that this medication will not be administered by a school nurse.**

Parent/Guardian Signature: _____Date:_____
Print Parent Name: _____
Home Phone: _____ Work Phone:_____
To promote safety for your child, medication information may be shared with school personnel working with your child and with 911 personnel, if they need to be contacted.

Parent/Guardian's Request and Authorization for Self Carry/Self-Administration

This authorization is given based on the following: My child is capable of and had been instructed in the proper method of self-administration of this medication. I understand that my child shall be permitted to carry, at all times, their medication as long as they do not endanger him/herself or other persons, and will not misuse the medication. I understand that if my child misuses by not taking the prescribed dosage, or endangers others with the medication, school employees or agents may confiscate the medication. I understand that this authorization shall be effective for this current school year and must be renewed annually.

Medication: _____Dose: _____ Possible side effects: _____
For treatment of: _____ Medication allergies: _____Print Physician Name: _____Phone:_____
Physician Signature: _____Date:_____
I, the parent/guardian, request this medication be given as prescribed. I release school personnel from any liability in the administration of this medication at school. I understand that I am responsible for communications with the health care providers ordering this medication. **I understand that this medication will not be administered by a school nurse.**

Parent/Guardian Signature: _____Date:_____
Print Parent Name: _____Home Phone: _____
Work Phone:_____
To promote safety for your child, medication information may be shared with school personnel working with your child and with 911 personnel, if they need to be contacted.