CENTRAL VALLEY CENTRAL SCHOOL DISTRICT
17 WEBER AVE.
ILION, NY 13357
Phone: (315) 574-3115 Fax: (315) 574-3116

PARENT and PRESCRIBER'S AUTHORIZATION for
ADMINISTRATION OF MEDICATION IN SCHOOL

STUDENT:_____ **DOB:**_____ **DISTRICT:** Central Valley CSD

PHYSICIAN:_____ **PHONE:**_____ F**AX:**_____

PHYSICIAN ADDRESS:_____

A. To be completed by parent or guardian:

I request that my child _____ grade _____ receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by my in the properly labeled, original container from the pharmacy. I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication.

Signature of Parent or Guardian: _____

Address: _____

Telephone: Home _____ Work: _____ Date: _____

B. To be completed by the licensed health care prescriber:

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

Diagnosis & **ICD-10 Code(s)**:_____

Name of Medication: _____

Prescribed Dosage, Frequency and route of Administration:

Time to Be Taken During School Hours: _____

Duration of Treatment: School Year **OR** _____

Possible Side Effects & Adverse Reactions (if any): _____

Other Recommendations: _____

Name of Licensed Prescriber and Title: _____

Please PRINT or STAMP

NPI# _____ LIC# _____

Signature: _____ Date: _____

Address: _____ Phone: _____