**IROQUOIS CENTRAL SCHOOL DISTRICT**
**HS: PHONE: 716-652-3000 EXT. 7600 FAX:716-995-2449**
**MS: PHONE: 716-652-3000 EXT. 6600 FAX: 716-995-2337**
**MEDICATION AUTHORIZATION FORM**

## A. TO BE COMPLETED BY THE PARENT OR GUARDIAN:

I request that my child _____DOB _____ Grade ___ receive the medication as prescribed below by our NYS licensed health care provider. I will furnish the medication in a properly labeled original container from my pharmacist or drug store.
If my child has been designated as an independent student by their healthcare provider, I agree they can use their medication effectively and may carry and use this medication independently at any school/school sponsored activity with no supervision by school staff.

Signature (Parent or Guardian): _____ Date _____

Telephone: Home _____ Work _____ Cell _____

## B. TO BE COMPLETED BY NYS LICENSED HEALTH CARE PROVIDER:

Name of Student _____ DOB _____

**Diagnosis:** _____

Known drug allergies: ☐No ☐Yes - Describe _____

List any other allergies: _____

I request that my patient receive the following medication:

| MEDICATION | DOSAGE | FREQUENCY | ROUTE OF ADMINISTRATION | LEVEL OF ASSISTANCE *SEE DEFINITIONS BELOW |
|---|---|---|---|---|
| | | | | ☐ Independent Student<br>☐ Supervised Student<br>☐ Nurse Dependent Student |
| | | | | ☐ Independent Student<br>☐ Supervised Student<br>☐ Nurse Dependent Student |

Duration of Treatment: _____

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

**NYS – Level of Assistance Definitions:**
**Independent Student:** No assistance is needed from school staff except during emergencies. May self-administer and carry medicine. A back up supply may also be kept in Health Office if desired.
I attest this student has demonstrated to me they can self-administer the medication(s) ordered above safely & effectively, and may carry and use this medication independently at any school/school sponsored activity with no supervision by school staff except in emergencies.

**Supervised Student:** Adult school staff trained by RN may assist student when taking medication ordered above. The medication will be kept in Health Office or with adult school staff at school/school sponsored activity (i.e. field trips).

**Nurse Dependent Student:** NYS RN, NP, Physician, or PA must administer medication(s). School staff may not assist student with medication.

NYS Licensed Prescriber and Title (print or stamp): _____

Physician's Signature _____ Date: _____

Address: _____ Phone: _____