STARPOINT CENTRAL SCHOOL

4363 Mapleton Rd. Lockport, NY 14094

Authorization for Medication Administration in **Grades 9-12 ONLY**

Instructions for Parent/Guardian:

1. All medication, including NON-PRESCRIPTION and prescription drugs, must be accompanied by this completed form. **We will be unable to administer any medication in school unless all requirements are met.** In case of field trips, a designated responsible person may be assigned to administer the medication.

2. All medication must be brought to school by parent or adult designee in its **original container** and be labeled with the student's name. For prescription medications, the pharmacist should be asked for a properly labeled second container. All orders expire on June 30th of the school year.

High School Health Office (Grades 9-12) **Phone: 210 2330** **Fax: 210 2361**

To Be Completed by Licensed Health Care Prescriber ONLY:

Physician's Order: Date:_____

Student's Name:_____ D.O.B._____

Diagnosis:_____

Name of Medication:_____

Dosage, route, frequency:_____

Time to be taken during school hours:_____

Duration of treatment:_____

Adverse reactions, side effects (if any):_____

_____

For Inhalers and Epi-pens:

Check ONE: ___*May carry inhaler/epi-pen ___May NOT carry inhaler/epi-pen

*He/she is considered responsible and has been instructed and understands the purpose, appropriate method and frequency of use.

Licensed Prescriber Signature:_____ Phone:_____

Printed:_____ Date:_____

Parent/Guardian consent:

I, the legal parent or guardian of _____ grade_____, similarly sanction the administration of the medication stated above.

Parent/Guardian Signature: _____ Date:_____

Daytime phone: _____ rev. 5/03