Cornwall Central High School and Cornwall Central Middle School

Student Health Services
Authorization to Administer Medication
(845) 534-8009

CCHS- Ext. 5010
Fax: (845) 565-4743

CCMS- Ext. 4010
Fax: (845) 534-8309

To be completed by health care provider

Student name:_____ DOB:_____
Allergies:_____

Medication:_____Dose:_____Route:_____Time(s):_____
_____

Health care provider permission for independent use and carry

☐ By initialing this box I attest that the above named student has demonstrated to me that they can safely self-carry/administer the medication listed above at school/school sponsored events. Staff intervention and support is needed only during an emergency.

_____ _____
Name/title of prescriber (please print) Date

_____ _____
Prescriber's signature Phone

_____
Fax/Email

Stamp

To be completed by parent/guardian

Student name:_____ DOB:_____

School:_____ Grade:_____ Teacher/HR:_____

Parent/guardian permission for independent use and carry

I agree with the medical provider's decision to allow my child to self-carry/administer the above named medication at school/school sponsored events independently and without supervision by school staff.

_____ _____ _____
Parent/guardian (please print) Parent/guardian (signature) Date

One medication per form, valid for the current school year only.