Cornwall Central School District
Elementary Student Health Services
Authorization to Administer Medication

(845) 534-8009

CES- Ext. 2010 **WAES- Ext. 3010** **COHES- Ext. 1010**
Fax: (845) 458-7953 **Fax: (845) 314-5849** **Fax: (845) 314-9351**

To be completed by health care provider

Student name:_____ DOB:_____ Allergies:_____

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

For PRN dosing only- Parameters for Administration_____

An appropriate medical professional authorized to administer medication in NYS will administer medication to the student. Medication must be stored in the school health office. For school sponsored events the nurse may determine that the student is able to self-administer their medication in which case a trained staff member will carry the medication if a nurse is not available.

By signing this form I attest that the above named student has a need for medication to be kept/administered at school and school sponsored events.

_____ _____

Name/title of prescriber (please print) Date

_____ _____

Prescriber's signature Phone

_____

Fax/email

Stamp

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

To be completed by parent/guardian DOB:_____

Student name:_____ Teacher:_____

School:_____ Grade:_____

Parent/guardian permission for nurse to administer medication

I agree with the medical provider's decision listed above. I understand that I am responsible to refill, deliver, and pick up my child's medication from the health office.

_____ _____ _____

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