



**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) 534-3474      Fax: (845) 534-2284**

**To be completed by health care provider**

Student name: \_\_\_\_\_ DOB: \_\_\_\_\_ Allergies: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Time(s): \_\_\_\_\_

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	<i>Stamp</i>
Prescriber's signature	Phone	
Fax/email		

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

**To be completed by parent/guardian**

Student name: \_\_\_\_\_ DOB: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

**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