NCCS HEALTH OFFICE
103 Rt. 276, Champlain, NY 12919
Middle School Nurse **High School Nurse**
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(518) 298-8681 Ext 3007 (518) 298-8638 Ext 2406
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PARENT AND HEALTHCARE PROVIDER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

A. To be completed by the Parent or Guardian:

I request that my child _____(Date of birth: _____) receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy*. I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication.

Signature (Parent or Guardian): _____

Telephone: Home _____ Work _____ Date _____

B. To be completed by the Private Healthcare Provider:

I request that my patient, as listed below, receive the following medication:

Name of Student _____DOB _____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Possible Side Effects and Adverse Reactions (if any):

Healthcare Provider's Signature _____ Date:_____

Address: _____ Phone: _____

* *Medication must be in original pharmacy labeled container with specific orders and name of medication.*

* *Medication and refills must be brought to school by parent, guardian or responsible adult.*

This medication order is valid for the current school year and summer school as needed.

Double sided