SARATOGA SPRINGS CITY SCHOOL DISTRICT

Caroline Street School- 518-583-4766 Ext.16149 (Fax) 682-2661
Geyser Road School- 518-583-4732 Ext.18137 (Fax) 583-4741
Lake Avenue School- 518-583-4772 Ext.15115 (Fax) 583-4702
Maple Avenue Middle School- 518-587-4551 (Fax) 583-4723
St. Clements- 518-584-7350 (Fax) 587-2623
Waldorf School- 518-584-7643 (Fax) 581-1466
Division Street School- 518-583-4756 Ext.17137 (Fax) 583-4722
Greenfield School- 518-893-2528 Ext.19866 (Fax) 893-7408
Dorothy Nolan School- 518-583-4748 Ext.14170 (Fax) 584-3222
High School- 518-587-6690 Ext.33385 (Fax) 581-7629
Saratoga Catholic- 518-587-7070 (Fax) 587-0678

Authorization to Administer Medication in School and School Activities

A. To be completed by the Parent or Guardian:

I request that my child ______________________________ receive the medication as prescribed below by our licensed healthcare provider. The medication is to be delivered by me in the properly labeled original container. I understand that if my child is to self-carry a non- emergent medication, he/she is to only carry enough for one day. The school nurse may contact the prescriber as needed.

Signature of Parent or Guardian: ______________________________ **Date:** __________

Telephone home: ____________________ **Work:** ____________________ **Cell:** __________________

B. To be completed by the Licensed Healthcare Provider:

*** THIS MEDICATION ORDER IS VALID FOR** ____________________

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

Name of Student: ______________________________ **DOB** ________________

MEDICATION	SELF-CARRY	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMISSION

DIAGNOSIS: ______________________________ **ICD- 10:** ________________

****Licensed Healthcare Provider Permission for Independent Use and Carry****

I attest that this student has demonstrated to me that he/she can self-administer the medication(s) listed above safely and effectively and may carry and use this medication (with a delivery device if needed) independently at any school/school sponsored activity with no assessment or supervision by school staff. This order applies only to the emergency medications checked above.

Licensed Healthcare Provider Name/Title (please print) ______________________________

Signature ______________________________ **Date:** ____________________

License # ______________________________ **NPI #** ____________________

Prescribers address and phone number:

____

____

____

Stamp:

CC: Student__________ **School Nurse Signature:** ______________________________

Updated: 5/2017, DM