Afton Central School District
Authorization for Medication Administration In School and for School Activities

To be completed by Parent/Guardian:

Student_____ DOB:_____
Grade:_____ Teacher (elementary students):_____ School Year:_____

I request that my child be given medication as specified below by their Physician or other Licensed Health Care Provider.
I also understand the following:

-All medication must be in its original container with: name of medication, dose, route, and frequency in the pharmacy labeled container.
- Medication and refills must be brought to school by the parent/guardian or other responsible *adult*.
- This medication order is only valid for the current school year.

Signature of parent / guardian: _____ **Date:**_____
Phone #: Home_____ Work_____ Cell_____

To be completed by Physician / Licensed Health Care Provider:
Diagnosis: _____
_____

Medication	Dose	Route	Time/Frequency	*Self-carry/self-administer
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No

Possible Side Effects and Adverse Reactions:
_____
_____
_____

*If the student is allowed to self-carry/self-administer, the Healthcare Provider and Parent signature indicate a request that this student be permitted to carry the medication on his/her person or to keep the same in his/her locker or P.E. locker, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use of the medication.

Physician/Licensed Provider Signature:_____ Date:_____
Print Name:_____
Phone #:_____