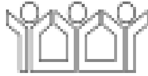


BEDFORD CENTRAL SCHOOL DISTRICT
School Health Services
THE FOX LANE CAMPUS, P.O. BOX 180
MOUNT KISCO, NEW YORK 10549
914-241-6000

Dr. Robert Glass
Superintendent of Schools

Dr. Louis Corsaro
Medical Director

GENERAL AUTHORIZATION FOR ADMINSTRATION OF PRESCRIPTION AND NON-PRESCRIPTION MEDICATION IN SCHOOL *(Non-epinephrine or Benadryl orders)*

New York State Education Law does not permit school personnel to dispense any medication (prescription or non-prescription) without written permission signed by the prescribing healthcare provider and the parent.

TO BE COMPLETED BY THE PHYSICIAN OR PRESCRIBING HEALTH CARE PROVIDER:

STUDENT'S NAME: ______________________ **DOB:** __________ **GRADE:** __________

Name of medication: ______________________

Dosage: ______________________ Route: __________ Frequency: __________

Diagnosis/reason: ______________________

Possible side effects: ______________________

Desired action: ______________________

Other comments: ______________________

______________________ ______________
Signature of Physician/Provider *Date*

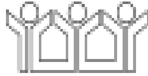
______________________ ______________
Print name: *Phone Number*

TO BE COMPLETED BY THE PARENT/GUARDIAN:

I hereby give my permission to the School Nurse to administer the above medication to my child as specified by the physician/provider.

______________________ __________ ______________
Signature of Parent/Guardian *Date* *Phone Number*

See reverse side for Self-Carry/Self Administration Instructions



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SELF-CARRY/SELF ADMINISTRATION INSTRUCTIONS:

To be completed by physician/prescriber:

I have instructed the above student in the appropriate use of this medication and the student may be permitted to self-carry and self-administer this medication if approved by the School Nurse.

____ ______________________

Signature of Physician/Provider *Date*

To be completed by the parent/guardian:

When appropriate, I give permission for my child to self-administer the above medication as per the physician/prescriber and the School Nurse.

____ ______________________

Signature of Parent/Guardian *Date*

To be completed by the School Nurse:

I have assessed the above named student for self-carry and self-administration and approve their doing so.

____ ______________________

Signature of School Nurse *Date*