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 #: _____

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: _____

Telephone: _____

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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/prescriber:_____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.
Parent/Guardian signature:_____ 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:_____