SALMON RIVER CENTRAL SCHOOL DISTRICT
SUPERINTENDENT'S OFFICE

637 Co. Rt. 1, Fort Covington, New York 12937 • Tel: (518) 358-6600 • Fax (518) 358-2145

PHYSICIAN AND PARENT AUTHORIZATION FOR

ADMINISTRATION OF MEDICATION IN SCHOOL

A. To be completed by Physician:

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

Name of Student _____DOB_____

MEDICATION_____DOSAGE_____

FRQUENCY/TIME TO BE TAKEN_____

ROUTE OF ADMINISTRATION_____

Possible side effects and adverse reactions (if any):

**Diagnosis_____*ICD10 code_____

Physician's Signature_____Date:_____

Address:_____Phone:_____

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Diagnosis and ICD 10 code **MUST be included

B. *To be completed by parent or guardian*:

I request that my child _____DOB_____

receive the medication as prescribed above by our physician. The medication is to be furnished by me in the properly labeled container from the pharmacy.

Parent or Guardian signature: _____Date:_____

Phone: _____Work Number:_____