

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:

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:

***THIS MEDICATION ORDER IS VALID FOR ONE YEAR UNLESS OTHERWISE NOTED ***

CC: Student _____

CC: Student Folder

CC: Medication Book