CANASTOTA JR./SR. HIGH SCHOOL
Canastota, NY 13032
Fax number: 315-951-2375

PARENT AND PRESCRIBER'S
AUTHORIZATION FOR ADMINISTRATION OF MEDICATION
FOR OVERNIGHT SCHOOL-SPONSORED TRIPS

A. To be completed by the Parent/Guardian:

I request that my child, _____ , in Grade_____, receive the medication as prescribed below by our licensed health care provider. The medication is to be furnished by me, in the properly labeled and original container from the pharmacy, and is to include only the amount my child will require during the overnight trip. I understand that the school nurse will administer or another designated person in the event of the school nurse's absence, will administer or assist with the administration of the medication. All medication will be under the control of the nurse or designated person throughout the duration of the trip, unless indicated as a self-carried /administered medication by the prescribing provider (see note below).

Parent/Guardian Signature_____ Date_____
Address _____
Phone Numbers: Home_____ Work_____ Cell_____

B. To be completed by the Licensed Health Care Provider:

I request that my patient, as listed below, receive the following medication:
Student's Name_____ DOB_____
Diagnosis_____
Medication_____
Prescribed Dose _____ Route_____ and frequency of administration_____
Time(s) to be taken during the overnight trip_____
Duration of treatment (date(s) of trip)_____
Possible side effects and adverse reactions (if any)_____
Other recommendations_____

I deem this student to be self-directed: Yes___ No___
Student may self-carry and self-administer medication*: Yes___ No___
*Note: Applies only for inhalers, oral contraceptives, and anaphylactic medications.

Printed name and title of licensed prescriber_____
Prescriber's Signature_____ Date_____
Address_____ Phone _____