Cairo-Durham Central School District
Health Office
Administration of Medication in School
2019 - 2020 School Year

Please check appropriate school:
( ) C-D Elementary School ( ) C-D Middle School ( ) C-D High School

To be completed by parent or guardian:

I request that my child _____ grade _____ receive the medication as prescribed below by our licensed health care prescriber. The medication will be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse will administer the medication or an adult will supervise my child taking his/ her own medication.

_____ _____
Signature of Parent/Guardian Date

Telephone: Home _____ Work _____ Cell _____

To be completed by the licensed health care prescriber:

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

Name of Student _____Date of Birth _____

Diagnosis _____

Medication _____

Prescribed Dosage, Frequency and Route of Administration

_____

Time to be Taken During School Hours _____

Duration of Treatment _____

Possible Side Effects and Adverse Reactions (if any)

_____

Other Recommendation _____

_____
Name of Licensed Prescriber and Title (Please Print)

_____ _____
Signature of Prescriber Date