Horseheads Central School District

1 Raider Lane, Horseheads, NY 14845 (607) 739-5601

Physician's Order for Giving Medication at School

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Student's Name: _____ DOB: _____ Gender: _____

Student's Address: _____

_____

Parent/Guardian Name: _____

Phone #(s): _____home _____work _____cell

To Physicians & Parents of Children requiring Medication in School:
In compliance with the rules and regulations of the New York State Education Department, you are requested to complete this form so that required medication may be administered in school to your child.

Name of Drug(s): 1)_____2)_____3)_____4)_____

Generic Name of Drug(s) if possible:1)_____2)_____3)_____4)_____

Dosage & Frequency:1)_____2)_____3)_____4)_____

Expected Effect(s): 1)_____2)_____3)_____4)_____

Possible Side Effect(s): 1)_____2)_____3)_____4)_____

Diagnosis: 1)_____2)_____3)_____4)_____

Time Duration of Order: 1)_____2)_____3)_____4)_____

Date Order is Effective: 1)_____2)_____3)_____4)_____

Signed Physician's Name: _____ ***Date Signed:*** _____

Physician's Address & Phone #: _____
Street Address/PO BOX #

_____
City *State* *Zip Code* *Phone #*

Physician's NPI or License #: _____
NPI # *License #*

Parent Request for School to give Medication:

I hereby request that my child _____ be given the medication above as prescribed by the
Student's Name
Physician.

_____ _____
Parent/Guardian Signature *Date*

Physician/Parent Request for Student to be allowed to Self Medicate at School/Work Place if need arises:

_____ has been instructed in the proper method of self administration of the following
Student's Name
prescribed medication(s): _____

_____

It is our belief that this student is knowledgeable and responsible enough to carry, store and use said medication(s) during school and extracurricular hours. He/She has been instructed in and understands the purpose and appropriate method and frequency of use of said medication(s).

_____ _____
Parent/Guardian Signature *Date*

_____ _____
Physician's Signature *Date*

11/03/10 SS