Tully Central School District
Administration of Medication in School
Parent and Healthcare Provider's Authorization

A. To be completed by the Parent or Guardian:

I request that my child _____ receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy. The school nurse may contact the prescriber as needed.

Signature (Parent or Guardian): _____

Telephone: Home _____ Work _____ Cell _____ Date _____

B. To be completed by the Private Healthcare Provider:

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

Name of Student _____ DOB _____

Diagnosis: _____ ****ICD-10:** _____

MEDICATION	SELF-CARRY	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMIN.

Healthcare Provider's Printed Name with title: _____

Signature _____ **Date (Full)** _____

License #: _____ Phone _____

Complete Address: _____

* *Medication must be in original pharmacy labeled container with specific orders and name of medication.*