BALLSTON SPA CENTRAL SCHOOL DISTRICT
Administration of Medication in School and School Activities
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:** _____

Health Care 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 below 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 supervision by school staff. This order applies only to the emergency medications checked below:

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

Healthcare Provider's Printed Name with **title**:_____

Signature _____ **Date (Full)**_____

License #: _____**NPI #**: _____Phone_____

Complete Address: _____

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

This medication order is valid for July 1, 2023- June 30, 2024.