LOWVILLE ACADEMY and CENTRAL SCHOOL
7668 NORTH STATE STREET
LOWVILLE, NEW YORK 13367-1328
Fax: (315)376-9021

For School Use:
Grade/Teacher: _____

Date Received: _____

Request for Administration of Medication in School

Student: _____ DOB: _____

To be completed by authorized NYS licensed prescriber:

Name of medication: _____

Reason for medication: _____ ICD Code _____

Dose: _____Route: _____ Time to be given: _____
***Note:** Medication will be given as close to the prescribed time as possible, but may be given up to one hour before or after the prescribed time. Please advise if there is a time-specific concern regarding administration.

Start: ____ Date form received. Other date: _____

Stop: ____ End of school year/ or summer school if attending. Other date: _____

Restrictions and/or important side effects: ____ None anticipated.

____ Yes. Please describe: _____

Prescriber Signature: _____ Date: _____

Prescriber Stamp: Phone: _____

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To be completed by parent/guardian:

I request that my child _____receive the medication as prescribed above by our licensed health care provider. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse, or other designated person in case of the absence of the school nurse, will administer the medication.

Parent/ Guardian Signature: _____ Date: _____

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For inhalers and emergency medications (EpiPen, Benadryl, Diabetes etc.):
This student is both capable and responsible for self – administration of this medication. He/she is self-directed and is able to recognize and knows how, when, and why to use this medication:

This student may carry and self-administer this medication: ____Yes ____ No

Prescriber Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____