Sherburne – Earlville Elementary School

Phone: 607-674-7336 Fax: 607-674-8440

The following section is to be completed by the **Parent/Guardian:**

Student Name _____ DOB _____

Health Care Provider's Name _____

Health Care Provider's Address & Telephone Number _____

_____

I request that my child be assisted in taking the medication(s) described below at school by the authorized person(s).

The medication is to be provided in a properly labeled original container from the pharmacy.

_____

Parent/Guardian Signature Date Home Phone # Emergency Number

The following section is to be completed by the **Health Care Provider:**

Name of Medication _____

Dose _____ Frequency _____ Time _____

Diagnosis for which medication is given _____

List ***significant side effects*** _____

Length of time this treatment is recommended (current school year) _____

Other information _____

Is child authorized to self-medicate? (Inhaler or Bee Sting Kit ONLY) _____

Student may self-medicate *and carry medication*? _____ yes _____ no

_____ I attest that this student has demonstrated to me that he/she can self-administer the medication(s) listed above safely and effectively and may carry and use this medication (with a delivery device if needed) independently at any school or school-sponsored activity with no supervision by school staff.

Health Provider's Signature _____ Date _____