



Upton Lake Christian School
P.O. Box 63
Clinton Corners, NY 12514
845-266-3497
www.uptonlake.com

AUTHORIZATION FOR MEDICATION

For in school and school activities. This form is for students to carry and administer their own medication. You are attesting that you have determined the student is able to carry the medication responsibly, and to self administer the medication effectively without supervision.

TO BE COMPLETED BY THE PROVIDER

Student Name _____ DOB _____ Grade _____
Diagnosis _____
Medication Name: _____ DOSE: _____ Route and time _____

Please check one box: Nurse or parent designee to administer medication ()

Self administer with staff supervision ()

Independent carry and self administer ()

Provider Name _____ Phone _____
Provider Address _____
Provider Signature _____ Date _____

Provider Stamp

TO BE COMPLETED BY PARENT OR GUARDIAN

Check box and sign only one of the following options:

() I request for my child to be given the medication prescribed above. I will provide the medication in the original pharmacy or over the counter container.

Parent/Guardian signature _____ Date _____

() Self administered with the supervision from the nurse. I will provide the medication in the original pharmacy or over the counter container.

Parent/Guardian signature _____ Date _____

() Independent Carry and Administer permission. I agree that my child can independently carry and administer the medication prescribed above without any supervision from the school staff.

It is highly recommended that any medication be stored in the nurse's office locked cabinet to be administered as needed

No medication should be shared with any other student.

Parent/Guardian Name _____
Parent/Guardian Signature _____ Date _____