WCSD

Wallkill Central School District, 1500 Route 208, PO Box 310, Wallkill, New York 12589
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Kevin Castle
Superintendent of Schools

Anthony White
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for Educational Services

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Assistant Superintendent
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Authorization for Administration of Medication and/or Procedures

Please note: Any medication MUST be delivered directly to the school Health Office by the PARENT. Medication may NOT be taken to or from school by the student or on the bus. If you have any questions, please contact the Health Office at your child's school.

Wallkill Senior High School	*Telephone:*	*895-7155*	*Fax:*	*895-7173*
John G. Borden middle School	*Telephone:*	*895-7181*	*Fax:*	*895-7182*
Leptondale Elementary School	*Telephone:*	*895-7206*	*Fax:*	*895-7204*
Claire F. Ostrander Elementary School	*Telephone:*	*895-7231*	*Fax:*	*895-7229*
Plattekill Elementary School	*Telephone:*	*895-7256*	*Fax:*	*895-7262*

A. This section is to be completed by parent/guardian:

_____ *Grade_____* *Date of Birth_____/_____/_____*
(Student name)

I request that the above named student receive the medication or procedure described below. I will furnish the medication in a properly labeled original container from the pharmacy. I understand that the school nurse will administer the medication or an adult will supervise my child taking the medication.

_____ _____
(Parent/Guardian Signature) *(Date)*

B. This section is to be completed by the licensed prescriber:

I request that my patient receive the following medication/procedure:

Diagnosis: _____ Medication: _____ Dosage/Frequency: _____

Time of Admin: _____ Duration of Treatment: _____ Possible Side Effects: _____

Other Recommendations: _____

_____ _____
(Name of Licensed Prescriber/Title) *(Prescriber's Signature)*

_____ _____
(Address of Licensed Prescriber) *(Telephone # of Licensed Prescriber)*

We request that the above named student be permitted to carry the medication on his or her person or to keep some in his or her locker as we consider him or her responsible. The student understands the purpose and appropriate method and frequency of use of the medication or treatment.

_____ _____
(Physician's Signature) *(Date)*

_____ _____
(Parent/Guardian Signature) *(Date)*