Global Concepts Charter School
1001 Ridge Road
Lackawanna, New York 14218
716-821-1903

A. To be completed by the Parent or Guardian:

I request that my child, _____ DoB_____ receive the medications as prescribed below by our physician, The medication is to be furnished by me in the properly labeled original container from the pharmacy.

PLEASE CHECK ONE:

☐ I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication, including field trips, to my designated self-directed child.

☐ I understand that the administration of oral, topical, or inhalant medications to my **non** self-directed child, and injectable medications must remain the responsibility of the school nurse, licensed practical nurse under the direction of a school nurse, physician, or parent.

Signature (Parent or Guardian): _____

Telephone: Home _____ Work _____ Date _____

B. To be completed by physician:

I request that my patient, as listed below, receive the following medication:

Name of Student _____ DoB_____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment:

Possible Side Effects and Adverse Reactions (if any):

Physician's Signature _____ Date _____

Address: _____ Phone _____

* Medication must be in original pharmacy labeled container with specific orders and name of medication
* Medication and refills must be brought to school by parent, guardian, or responsible adult.

Plan Reviewed with parent(s) / Guardian(s):

Parent Signature: _____ Date _____