# Cornwall Central High School and Cornwall Central Middle School

## Student Health Services
## Authorization to Administer Medication
## (845) 534-8009


**CCHS- Ext. 5010**
**Fax: (845) 314-9203**

**CCMS- Ext. 4010**
**Fax: (845) 534-8309**


**To be completed by health care provider**

Student name:____________________________________ DOB:__________________ Allergies:____________________________

Medication:______________________________Dose:_________________Route:__________________Time(s):_______________

**Health care provider permission for independent use and carry**

☐ By initialing this box I attest that the above named student has demonstrated to me that they can safely self-carry/administer the medication listed above at school/school sponsored events. Staff intervention and support is needed only during an emergency.

_____________________________________________ ____________________
Name/title of prescriber (please print) Date

_____________________________________________ ____________________
Prescriber's signature Phone

__________________________________________________________________
Fax/Email

*Stamp*

**To be completed by parent/guardian**

Student name:_______________________________________________ DOB:_____________________

School:______________________ Grade:_____________________ Teacher/HR:_____________________

**Parent/guardian permission for independent use and carry**

I agree with the medical provider's decision to allow my child to self-carry/administer the above named medication at school/school sponsored events independently and without supervision by school staff.

____________________________________________ ____________________________________________ __________________
Parent/guardian (please print) Parent/guardian (signature) Date

***One medication per form, valid for the current school year only.***

Updated 9/6/22