HONEOYE FALLS-LIMA
Central School District
Community Programs & Aquatics Department
Office: (585) 624-7068
Fax: (585) 624-7138

"Education is the Foundation for Success"

Honeoye Falls – Lima *Cougar Care* Before and After School Care Program
Authorization for Administration of Medication

Student Name:_____ School:_____

Date of Birth:_____ Grade:_____

A. To be completed by Parent/Guardian:

I request that my child receive the medication(s) as prescribed below. The medication must be delivered to the *Cougar Care* supervisor by parent/guardian in the properly labeled original container from the pharmacy. I understand that a staff person will administer the medication and that this request must be renewed annually or whenever there is a change in the original prescription.

Parent or Guardian: Date:_____

Name:_____ Signature_____

Address:_____

Home Phone:_____ Work Phone:_____

B. To be completed by Health Care Provider:

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

Name of Patient:_____ Date of Birth_____

Diagnosis_____

Name of Medication:_____

Prescribed Dosage, Frequency and Route of Administration: _____

_____

Time(s) to be taken during program hours:_____ Duration of Treatment_____

Possible Side Effects/Adverse Reactions:_____

Other Recommendations:_____

Name of Health Care Provider (please print):_____ Title:_____

Address:_____ Phone:_____

Health Care Provider's Signature:_____ Date:_____