

Provider and Parent Permission to Administer Medication at School/School Sponsored Events

Student Name: _____ DOB: _____

Grade: _____ Teacher/HR: _____ School: _____

I request the school nurse give the medication listed on this plan; or after the nurse determines my child can take their own medications; trained staff may assist my child to take their own medications. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with school staff caring for my child.

Parent/Guardian Signature

Date _____

Email

Phone Where We Can Reach You ☐ Check if Cell☐ Check if Cell

Diagnosis _____

Medication _____

Dose _____ Route _____ Time(s) _____

Recommendations	ICD Code
-----------------	----------

Note: Medication will be given as close to the prescribed time as possible, but may be given up to one hour before or after the prescribed time. Please advise if there is a time-specific concern regarding administration.

☐ Per MEDICAID requirements, frequency & duration as indicated "per" IEP when appropriate.

☐ Independent Carry and Use Attestation Attached (Required for Independent Carry and Use)

NYS law requires both provider attestation that the student has demonstrated they can effectively self-administer inhaled respiratory rescue medications, epinephrine auto-injector, Insulin, carry glucagon and diabetes supplies or other medications which require rapid administration along with parent/guardian permission delivery to allow this option in school. Check this box and attach the attestation to this form to request this option.

Name/Title of Prescriber (Please Print)

Date _____

Prescriber's Signature

Phone

Email

Stamp

Return to:

School Nurse: _____ School: _____

School Address: _____

Phone: () Fax: () Email: _____

PROVIDERS – PLEASE SEE OTHER SIDE FOR INDEPENDENT CARRY AND USE

GOSHEN CENTRAL SCHOOL DISTRICT

PROVIDER ATTESTATION AND PARENT PERMISSIONS FOR INDEPENDENT MEDICATION CARRY AND USE

Directions for the Health Care Provider: This form may be used as an addendum to a medication order which does not contain the required diagnosis and attestation for a student to independently carry and use their medication as required by NYS law. A **provider order** and **parent/guardian permission** are needed in order for a student to carry and use medications that require rapid administration to prevent negative health outcomes. These medications should be identified by checking the appropriate boxes below.

Student Name: _____ **DOB:** _____

Health Care Provider Permission for Independent Use and Carry

I attest that this student has demonstrated to me that he or she can self-administer the medication(s) listed below safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency. This order applies to the medications checked below:

This student is diagnosed with:

- ☐ Allergy and requires Epinephrine Auto-injector
☐ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication
☐ Diabetes and requires Insulin/Glucagon/Diabetes Supplies
☐ _____ which requires rapid administration of _____
(State Diagnosis) (Medication Name)

Signature: _____ **Date:** _____

Parent/Guardian Permission for Independent Use and Carry

I agree that my child can use their medication effectively and may carry and use this medication independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency.

Signature: _____ **Date:** _____

Please return to School Nurse:

School Nurse:		School:
Phone #:	Fax:	Email: