



Woestina Pre-K Health Office

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Jefferson Elementary Health Office

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Middle School Health Office

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High School Health Office

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Permission for Medication Administration in School and at School-Sponsored Events

Student's Name _____ Birth Date _____ Grade _____ School Year _____

Schalmont strongly recommends that all medications be administered at home. If any medication, including over-the counter and prescription, is medically necessary during the school day, **NYS Education Law requires the following conditions to be satisfied:**

- 1) Health Care Provider's written order, indicating the name, dose, frequency and route of the medication.
- 2) Parent/Guardian's written authorization to administer the medication as prescribed by the Health Care Provider.
- 3) Delivery of medication directly to the school nurse by a parent/guardian. Never send medications to school with the student or in the student's backpack.
- 4) Medication must be in a properly labeled pharmacy container for prescription medications and unopened manufacturer's container for over-the-counter medications. Pills in baggies will not be accepted.
- 5) Second identically labeled prescription bottle is required for daily medications to be administered at school day field trips.
- 6) Medication permission forms are valid for one school-calendar year. A new form must be submitted each new school year.

To Be Completed By HEALTH CARE PROVIDER

1. Medication _____
Dosage _____
Route _____
Time/Frequency _____
Duration _____
Diagnosis/Reason _____
Comments/Side-effects _____

2. Medication _____
Dosage _____
Route _____
Time/Frequency _____
Duration _____
Diagnosis/Reason _____
Comments/Side-effects _____

If the morning dose usually given at home has been forgotten, the nurse may administer it at school after verbal or written notification from the parent.

Medication _____ AM Dose _____

The above medication is medically necessary during the school day. I assess this student's functional category to be:

- Supervised:** Is *self-directed*, as defined by the ability to: state the name, amount, time and effect of taking/not taking this medication; demonstrate how to take the medication correctly; and recognize the medication and refuse the wrong medication or dose from an adult. Student may be assisted to take this medication under supervision by the school nurse and/or trained staff.
- Nurse Dependent:** Is *not self-directed* as defined above and requires a licensed health professional to administer this medication in school and at school-sponsored events until the student is able to demonstrate self-direction to the school nurse.

HCP Signature _____ Date _____

Printed Name _____ Phone _____

To Be Completed By PARENT/GUARDIAN

I request the school nurse administer this medication to my child as ordered above. I agree with the above functional category assessment. If and when my child is determined to meet the criteria for being *self-directed* by the school nurse, trained staff may assist my child to take this medication under supervision in school and at school-related events. I authorize the school nurse to discuss concerns regarding this medication with the prescribing Health Care Provider. I will provide the medication directly to the school nurse 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 _____

Printed Name _____ Phone _____

Parent/Guardian Email _____



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Provider and Parent Permissions Required 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 is 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: _____ **Date of Birth:** _____

I attest that this student has demonstrated to me that they 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 with no supervision by school staff. 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 with no supervision by school staff.

Signature: _____ **Date:** _____

Please return to your child's school nurse. Thank you.