Schalmont CENTRAL SCHOOL DISTRICT

Jefferson Elementary Health Office
Jill Facteau, LPN - jfacteau@schalmont.net
Phone: 518-355-1342 ext. 5036 | Fax: 518-704-4750

Schalmont Middle School Health Office
Cheryl Glindmyer, RN - cglindmyer@schalmont.net
Phone: 518-355-6255 ext. 2062 | Fax: 518-631-2544

Schalmont High School Health Office
Tara Bush, RN - tbush@schalmont.net
Phone: 518-355-6110 ext. 3041 | Fax: 518-557-1076

Student Medication Form

I hereby give permission for you to administer medication as prescribed by

_____ for _____.
(Physician) (Name of Child)

It is understood that no medication can or will be administered by the school nurse until both the parental permission form and the doctor's signed directions are on file in the nurse's office.

☐ Please check box if your child may carry and self-administer an inhaler.
☐ Please check box if your child may carry and self-administer an epipen.

_____
Parent/Guardian Signature

To: Physician
From: Schalmont Central School
Re: Medication

The following information is required for nurses to administer medication in school to students during the school day.

Student: _____

Diagnosis: _____

Medication: _____

Dosage: _____

Frequency: _____

Initiation date for medication: _____

Ending date for medication: _____

Medication: _____

Dosage: _____

Frequency: _____

Initiation date for medication: _____

Ending date for medication: _____

☐ Please check box if your child may carry and self-administer an inhaler.
☐ Please check box if your child may carry and self-administer an epipen.

_____ _____
Physician Signature Date

Please return to your child's school nurse.

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.