|  |
| --- |
| **Middle Country Central School District****Dept of Health, Physical Education & Athletics** |
| C:\Users\mvonlang\Desktop\LOGO Revised\MC-Color.png**145 Marshall Drive • Selden, NY 11784****631-285-8650 • 631-285-8151 (fax) •** [**www.mccsd.net**](http://www.mccsd.net) |
|  | *Roberta A. Gerold, Ed.D., Superintendent of Schools**Francine McMahon, Deputy Superintendent for Instruction**Herbert B. Chessler, Assistant Superintendent for Business* *James G. Donovan, Assistant Superintendent for Human Resources* *Joseph Mercado, Director of Health, Physical Education & Athletics* |

**NYSCSH PROVIDER ATTESTATION & 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)

**Physician Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Office Stamp:**

**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: Mrs. Cleary, RN and Mrs. Powell, RN | School: Dawnwood Middle School |
| Phone #: 631-285-8220 | Fax: 631-285-8262 | Email:  |