|  |  |  |  |
| --- | --- | --- | --- |
|  Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Gender: M F |  |
|  School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Teacher:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Grade:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |
| **PROVIDER REQUEST FOR MEDICATION REQUIRED DURING SCHOOL/SCHOOL SPONSORED EVENTS - VALID 1 ACADEMIC YR** |
| Diagnosis | ICD Code | Medication Name | Dose | Route | Time |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **The medications listed above have the following:** **START DATE:**  Date form received or  Other (please specify)\_\_\_\_\_\_\_\_\_\_ **STOP DATE:**  End of Academic School year or  Other (please specify)\_\_\_\_\_\_\_\_\_\_**Independent Carry and Use Option:** NYS law requires both provider attestation that the student has demonstrated they can effectively self-administer inhaled respiratory rescue medication, epinephrine auto-injector, insulin, glucagon and diabetes supplies, or other medications requiring rapid administration along with parent/guardian permission to allow this option in schools.**DO NOT allow student to carry and independently self-administer medication****Health Care Provider Permission for Independent Use and Carry:** I **attest** that this student has demonstrated to  me that they can self-administer the medications listed above 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. |
| **HEALTH CARE PROVIDER** |
| **All information contained herein is valid for the following academic school year:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.** Medical Provider Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Provider Name: (please print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: ( ) |
|  Provider Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: ( ) |
| **REQUIRED PARENT/GUARDIAN PERMISSION FOR MEDICATION USE AT SCHOOL** |
| **Parent/Guardian Permission**: I request the school nurse give the medications 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 staff caring for my child. Parent/Guardian 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.  Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |