EMBRACE CHALLENGE,
DISCOVER YOURSELF.

Nichols School Health Care Provider and Parent Authorization for Administration of Medication in School

To be completed by the parent or guardian:

I authorize the school health staff to give my child _____, grade _____ the following prescription or over the counter medication as prescribed by our licensed health care provider. After the school nurse determines that my child can take their own medications, other trained staff may assist my child to take their own medications.

All medication is to be provided to the school nurse in the properly labeled original container from the pharmacy.
THIS APPLIES TO PRESCRIPTION AND OVER THE COUNTER MEDICATION.
Medication not picked up from the health office by the last day of school will be discarded by the school nurse.

Signature (Parent or Guardian):_____ Date: _____

Address: _____

Telephone: Home:_____ Work:_____ Cell:_____

To be completed by the Licensed Health Care Provider: **VALID FOR ONE YEAR**

I request that my patient, as listed below, receive the following medication:

Name of Student: _____ Date of Birth: _____

Diagnosis: _____

Name of Medication(s), dosage, frequency, route, and time to be taken during school hours_____
_____
_____
_____
_____

☐ 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 that require rapid administration along with parent/guardian permission to allow this option in school. Check this box and attach the attestation to this form to request this option.)

Name of Licensed Health Care Provider and Title: (please print):

_____

Licensed Health Care Provider's signature: Date:

_____ _____

Address: Phone:

_____ _____