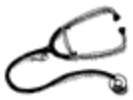
MOUNT PLEASANT CENTRAL SCHOOL DISTRICT

Medication Administration Order Form
for School and School Activities



Student Name: _____ DOB/Grade: _____ Teacher/HR: _____

Parent/Guardian Name: _____ Telephone: _____

Orders To Be Completed By Health Care Provider

Diagnosis (must be included) and Medication Name	Dose	Route	Frequency (Time)	Sign, Symptom or Situation (if prn)	☑ applicable boxes below
					☐ Independent Student ☐ Supervised Student ☐ Nurse Dependent
					☐ Independent Student ☐ Supervised Student ☐ Nurse Dependent
					☐ Independent Student ☐ Supervised Student ☐ Nurse Dependent

For any medication that is considered "Rapid Administration" (e.g. inhalers, diabetic medications) please complete the NYSCSH Provider Attestation and Parent Permission Form

Prescriber: Please choose level of supervision needed for each medication ordered

Independent Student	I attest that this student has demonstrated to me that he/she can self-administer the medication(s) noted above safely and effectively, and may carry and use this medication independently at any school/school sponsored activity with no supervision by school staff. **This code cannot be used for Grades K-2.**
Supervised Student	I attest that this student is self-directed regarding his/her medication. He/She understands the purpose, name, amount, dose, timing and effect of taking or not taking the medication. Recognizes what medication looks like and if/when to refuse to take it. The **school nurse**, or **designated person** in the absence of the school nurse, will assist the student in taking his/her medication. Medication is kept in the Health Office.
Nurse Dependent Student	I attest that this student is non-self-directed. A nurse **must administer** the student's medication.

Name/Title of Licensed Prescriber (Print) _____

Stamp

Prescriber's Signature _____ **Date** _____ **Phone** _____

To Be Completed By Parent

I give permission for the above medication to be administered to my child as ordered by my Health Provider. I will furnish the medication in the **original pharmacy container**, properly labeled with directions and dosage, or original over-the-counter medication container/packaging with my child's name on it. I will deliver medication to Health Office if my child is not deemed independent.

In addition, parent permission along with provider consent is required for students to self-administer and self- carry medication. Students identified with this designation are independent in taking their medication at school and require no supervision by the nurse or school staff. Parents assume responsibility for ensuring that their child is carrying and taking their medication as ordered. Schools may revoke the self-carry/ self-administer privilege if the student proves to be irresponsible or incapable.

A new order form is required for each new school year.

Parent/Guardian Signature_____ **Date** _____ **Phone** _____