MAMARONECK UNION FREE SCHOOL DISTRICT

Medication Permission Sheet

at School/School - Sponsored Events

To Be Completed By Parent

Student Name: _____ DOB: _____

Grade: _____ Teacher/Counselor_____ School: _____

I request the school nurse give the medication listed on this plan; trained staff may assist my child to take his/her own medications. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with school staff caring for my child.

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Email **Phone Where We Can Reach You** ☐ **Check if Cell**

Parent signature gives permission to speak to student's physician/ practitioner and school staff as needed

To Be Completed By Health Care Provider-Valid for School Year

Diagnosis: _____

Medication: _____

Dose: _____ **Route:** _____ **Time(s):** _____

Recommendations_____

Note: Medication will be given as close to the prescribed time as possible, but may be given up to one hour before or after the prescribed time. Please advise if there is a time-specific concern regarding administration.

☐ **Independent Carry and Use Attestation Attached (Required for Independent Carry and Use)**

NYS law requires both provider attestation that the student has demonstrated he/she can effectively self- administer inhaled respiratory rescue medications, epinephrine auto-injector, Insulin, glucagon and diabetes supplies or other medications which require rapid administration along with parent/guardian permission delivery to allow this option in school. Check this box and attach the attestation to this form to request this option.

_____ _____

Name/Title of Prescriber (Please Print) **Date**

_____ _____

Prescriber's Signature **Phone**

Stamp

PLEASE RETURN TO THE SCHOOL NURSE