Manchester-Shortsville Central School District

"Red Jacket Schools"

School Health Services
1506 Route 21, Shortsville, NY 14548-9502
Web Page: www.redjacket.org

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PARENT AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

A. <u>To be completed by the Parent/Guardian:</u>

I request that my child, _____________________________________, grade, _________, receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse or other designated person in the case of the absence of the school nurse will administer the medication.

Signature (Parent/Guardian): ____ Date: ____________________
Telephone: Home ___________________________ Work ___________________________ Cell ___________________________

B. <u>To be completed by the Licensed Health Care Prescriber:</u>

I requested that my patient, as listed below, receive the following medication:
Name of Student: ____ Date of Birth: ____________________
Diagnosis: ____

MEDICATION	DOSAGE	FREQUENCY-TIME TO TAKE	ROUTE

Name of licensed prescriber and title (please print): ____
Prescriber's Signature: ____ Date: ______________________
Address: ____ Phone: ______________________

*****Medications must be in original pharmacy labeled container and brought to school by parent or guardian.*****

Health Care Provider Permission for Independent Use and Carry

I attest that this student has demonstrated to me that they can self-administer Inhaled Respiratory Rescue Medication, or Epinephrine Auto-injector, or Insulin/Glucagon/Diabetes Supplies (as 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 with no supervision by school staff.

Name of licensed prescriber and title (please print): ____
Prescriber's Signature: ____ Date: ______________________
Address: ____ Phone: ______________________

SELF MEDICATION FOR ASTHMA INHALERS RELEASE (recommended if above 5th grade)

We request that, ________________________, be permitted to carry the asthma medication on his/her person or to keep same in his/her locker or P.E. locker, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use.

Signature (Parent/Guardian): ____ Date: ______________________
Plan Reviewed with Parent(s)/Guardian(s): ____ Date: ______________________
School Nurse: ____ Date: ______________________

Mission

We will challenge all learners and work in partnership with students, parents, and community to achieve high standards.