CHEEKTOWAGA SLOAN SCHOOL DISTRICT

Provider and Parent Permission to Administer Medication
at School

To Be Completed By Parent

Student Name: _____ DOB: _____

Grade: _____ Teacher/HR: _____ School: _____

I request the school nurse give the medication 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 school staff caring for my child.

_____ _____
Parent/Guardian Signature Date

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

To Be Completed By Health Care Provider-Valid for 1 Year

Diagnosis _____

Medication _____

Dose _____ Route _____ Time(s) _____

Recommendations_____ ICD Code _____

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.

☐ **Per MEDICAID requirements, frequency & duration as indicated "per" IEP when appropriate.**

☐ **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 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

_____
Email

Stamp

Return to:
School Nurse: _____ School: _____
School Address: _____
Phone: ( ) _____ Fax: ( ) _____ Email _____