JAMESTOWN PUBLIC SCHOOLS

TRADITION OF EXCELLENCE SINCE 1867

Provider and Parent Permission to Administer Medication at School/School Sponsored Events

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.

☐ Independent Carry and Use Attestation

I attest that this student has demonstrated to me that he or she can self-administer the medication(s) listed below safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency.

_____ _____ _____

Name/Title of Prescriber (Please Print) **Prescriber's Signature** **Date**

_____ _____

Address **Phone**

Please return to:

School Nurse: _____ School: _____

Phone: ( ) _____ Fax: ( ) _____

Revised 6/2016