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

ara ser completado por el padre

Nombre del estudiante: ______________________________ Fecha de nacimiento: ______________

Grado: ______________ Profesor / HR: ______________________________ Escuela: ______________________

Solicito a la enfermera de la escuela que proporcione el medicamento que figura en este plan; o después de que la enfermera determina que mi hijo puede tomar sus propios medicamentos; El personal capacitado puede ayudar a mi hijo a tomar sus propios medicamentos. Proporcionaré el medicamento en la farmacia original o en el contenedor de venta libre. Este plan se compartirá con el personal de la escuela que cuida a mi hijo.

______________________________ ______________ ______________________

Firma del Padre / Tutor Fecha Teléfono

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

Diagnosis ____

Medication ____

Dose ____________________ Route ________________ Time(s) ______________

Recommendations____ ICD Code ____________

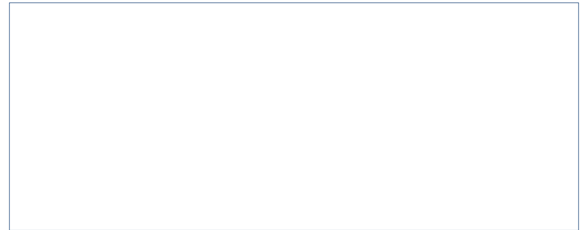
Note: Medication will be given as close to the prescribed time as possible, but may be given up to one hour before or after the prescribed time. Please advise if there is a time-specific concern regarding administration.

☐ **Independent Carry and Use Attestation 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.

____________________________________ __________ Stamp

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



________________________________ ______________

Prescriber's Signature **Phone**

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Email

PROVIDER ATTESTATION AND PARENT PERMISSIONS
REQUIRED FOR INDEPENDENT MEDICATION CARRY AND USE

Directions for the Health Care Provider: This form may be used as an addendum to a medication order which does not contain the required diagnosis and attestation for a student to independently carry and use their medication as required by NYS law. A **provider order** and **parent/guardian permission** is needed in order for a student to carry and use medications that require rapid administration to prevent negative health outcomes. These medications should be identified by checking the appropriate boxes below.

Health Care Provider Permission for Independent Use and Carry

I attest that this student has demonstrated to me that they 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. This order applies to the medications checked below:

This student is diagnosed with:

❑ Allergy and requires Epinephrine Auto-injector

❑ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication

❑ Diabetes and requires Insulin/Glucagon/Diabetes Supplies

❑ ______________________________which requires rapid administration of ____________________________

(State Diagnosis) (Medication Name)

Signature: ______________________________ Date: ________________

Permiso de los padres / tutores para uso independiente

y llevar Acepto que mi hijo pueda usar sus medicamentos de manera efectiva y que pueda llevar y usar este medicamento de forma independiente en cualquier actividad patrocinada por la escuela o la escuela. La intervención y el apoyo del personal son necesarios solo durante una emergencia.

Firma: ______________________________ Fecha________________

Return to: **School** Nurse: ____________________________ **School:** ________________________________ / Attention: Medical Office

Phone: ____________________________________ **Fax:** ____________________________________ R0118