

# Onteora Central School District

Bennett 657-2354

Middle/High School 657-2373

Woodstock 679-2316

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

### Para ser completado por los padres

Nombre del estudiante: \_\_\_\_\_ Fecha de nacimiento: \_\_\_\_\_

Grado: \_\_\_\_\_ Maestro/aula: \_\_\_\_\_ Escuela: \_\_\_\_\_

Solicito que la enfermera de la escuela me dé los medicamentos que se indican en este plan; o después de que la enfermera determine que mi hijo(a) puede tomar sus propios medicamentos, el personal capacitado puede ayudar a mi hijo(a) a tomar sus propios medicamentos. Le proporcionaré el medicamento en el envase original de la farmacia o en el envase de venta libre. Este plan se compartirá con el personal de la escuela que atiende a mi hijo(a). Entiendo que la enfermera de la escuela puede ponerse en contacto con mi proveedor de atención médica para aclarar los pedidos de medicamentos.

\_\_\_\_\_  
Firma de los padres/tutores

\_\_\_\_\_  
Fecha

\_\_\_\_\_  
Correo electrónico

\_\_\_\_\_  
Teléfono donde podemos comunicarnos con usted  Marcar si es celular

### 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.

\_\_\_\_\_  
Name/Title of Prescriber (Please Print) \_\_\_\_\_ Date \_\_\_\_\_ Stamp

\_\_\_\_\_  
Prescriber's Signature

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Email

### Return to:

School Nurse: \_\_\_\_\_ School: \_\_\_\_\_

School Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

Revised 3/8/17