SEAFORD UNION FREE SCHOOL DISTRICT

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.

☐ **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.

______________________________ ____________ Stamp
Name/Title of Prescriber (Please Print) Date

______________________________ ____________
Prescriber's Signature Phone

____
Email

Return to:
School Nurse: ______________________ School: ______________________
School Address: ____
Phone: ( ) ________________ Fax: ( ) ________________ Email ________________

AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION AT SCHOOL AND AFTER-SCHOOL ACTIVITIES

A. To be completed by the licensed healthcare provider:

(Student's name):____________________________ has been instructed in the

proper use of the following medication(s):____________________________

____

IN MY PROFESSIONAL OPINION, THIS STUDENT SHOULD BE ALLOWED TO CARRY AND USE THE ABOVE MEDICATION(S) BY HIM/HERSELF.

____________________________________ ____________
(Licensed Pescriber's Signature) (Date)

B. To be completed by parent or guardian:

I request that my child____________________________ be permitted to carry the above prescribed medication(s) on his/her person or to keep the above prescribed medication(s) in his/her locker or PE locker, as I consider him/her responsible. The student has been instructed in and understands the purpose, appropriate method, frequency and use of his/her medication. The student understands that he/she is responsible and accountable for carrying and using his/her medication. It is understood that if there is irresponsible behavior or a safety risk, the privilege of carrying his/her medication will be rescinded.

____________________________________ ____________
(Parent/Guardian Signature) (Date)

The licensed prescriber's statement and parent request are accepted. The student will be permitted to carry and use the prescribed medication. The parent will be contacted as soon as possible in the event of irresponsible behavior or safety risk.

____________________________________ ____________
(School Nurse Signature) (Date)

NOTE: This form must be completed *in addition* to the parent and prescriber's authorization form for administration of medication in school.

Date form received in health office: ____________