EASTCHESTER UNION FREE SCHOOL DISTRICT
580 White Plains Road
Eastchester, NY 10709
(914) 793-6130

Dear Parents/Guardians:

In preparation for the upcoming school year, please be aware that all medication orders are valid only for one year. Therefore, if your child will require prescribed/non-prescribed medication, the following must be completed. Medication must be in original pharmacy labeled container with specific orders and name of medication. Medication and refills must be brought to school by parent/guardian or responsible adult.

_____ _____ _____
Student Name Date of Birth Grade

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

❑Independent Medication Carry and Use

New York State law requires the provider attests that the student demonstrates they can effectively self-administer inhaled rescue medication, epi-pen, inhaler, glucagon to be administered in school. **Attestation and Parent Permission Required for Independent Medication Carry and Use release must be *completed by physician.***

Students diagnosed with seizures, diabetes, asthma or allergies must have an emergency action plan specific to that diagnosis *completed by a physician*.

For students that are involved in after-school activities, clubs or sports, it is the responsibility of the parent to convey medical information and/or medication to the responsible faculty/staff member.

I request that my child receive the medication as prescribed by our physician.

_____/_____
Name/ signature of parent

Signature of Physician: _____ Date: _____

STAMP

PLEASE RETURN TO THE SCHOOL NURSE

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EASTCHESTER, NY 10709
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ATTESTATION AND PARENT PERMISSION REQUIRED FOR INDEPENDENT MEDICATION CARRY AND USE

Directions for the Health Care Provider: This form must be used as an addendum to a medication permission sheet, it is an attestation for a student to independently carry and use his/her medication as required by NYS law. A **provider order** and **parent/guardian permission** are 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.

Student Name: _____ DOB: _____

Health Care Provider Permission for Independent Use and Carry

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

This student is diagnosed with:

- ❑ Allergy and requires Epinephrine Auto-injector
- ❑ Allergy and requires Antihistamine
- ❑ 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: _____

Parent/Guardian Permission for Independent Use and Carry

I agree that my child can use his/her medication effectively and may carry and use this medication independently at any school/school-sponsored activity. Staff intervention and support is needed only during an emergency.

Signature: _____ Date: _____

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Parent/Guardian Authorization of Another Adult (Designee) for Administration of Medication

To be Completed by Parent/Guardian:

I authorize staff member designee under the direction of school nurse to administer the following medication(s):

_____

_____

_____

To my child_____
(student name)

during school sponsored events/field trips.

I acknowledge that Eastchester Union Free School District will not be liable for any problems that may arise as a result of the administration of such medication by the designee.

Parent/Guardian signature: _____Date:_____

Print Name:_____

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