West Irondequoit Central School District

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PERMISSION FOR MEDICATION ADMINISTRATION IN SCHOOL AND AT SCHOOL-SPONSORED EVENTS

Student's Name ______________________________ **Birth Date**__________ **Gr**____ **School Year**_______

WCSD strongly recommends that all medications be administered at home. If any medication, including over-the counter and prescription, is medically necessary during the school day, ***NYS Education Law requires the following conditions to be satisfied:***

1) Health Care Provider's written order, indicating the name, dose, frequency and route of the medication.
2) Parent/Guardian's written authorization to administer the medication as prescribed by the Health Care Provider.
3) Delivery of medication directly to the school nurse by a parent/guardian. Never send medications to school with the student or in the student's backpack.
4) Medication must be in a properly labeled pharmacy container for prescription medications and unopened manufacturer's container for over-the-counter medications. Pills in baggies will not be accepted.
5) Second identically labeled prescription bottle is required for daily medications to be administered at school day field trips.
6) Medication permission forms are valid for one school-calendar year. A new form must be submitted each new school year.

To Be Completed By HEALTH CARE PROVIDER

1. Medication______________________	2. Medication______________________
Dosage______________________	Dosage______________________
Route ______________________	Route ______________________
Time/Frequency______________________	Time/Frequency______________________
Duration______________________	Duration______________________
Diagnosis/Reason______________________	Diagnosis/Reason______________________
Comments/Side-effects______________________	Comments/Side-effects______________________

☐ If the morning dose usually given at home has been forgotten, the nurse may administer it at school after verbal or written notification from the parent.

Medication ______________________ AM Dose ______________________

The above medication is medically necessary during the school day. I assess this student's functional category to be:

☐ **Supervised:** Is *self-directed*, as defined by the ability to: state the name, amount, time and effect of taking/not taking this medication; demonstrate how to take the medication correctly; and recognize the medication and refuse the wrong medication or dose from an adult. Student may be assisted to take this medication under supervision by the school nurse and/or trained staff.

☐ **Nurse Dependent:** Is *not self-directed* as defined above and requires a licensed health professional to administer this medication in school and at school-sponsored events until the student is able to demonstrate self-direction to the school nurse.

HCP Signature______________________________ Date______________

Printed Name______________________________ Phone ______________

To Be Completed By PARENT/GUARDIAN

I request the school nurse administer this medication to my child as ordered above. I agree with the above functional category assessment. If and when my child is determined to meet the criteria for being *self-directed* by the school nurse, trained staff may assist my child to take this medication under supervision in school and at school-related events. I authorize the school nurse to discuss concerns regarding this medication with the prescribing Health Care Provider. I will provide the medication directly to the school nurse 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______________

Printed Name______________________________ Phone ______________

Parent/Guardian E-mail____