



Rochester City School District
Student Health Services

PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION
BY SCHOOL PERSONNEL

Name of Student: _____ Date of Birth: _____

The Rochester City School District now requires an ICD-10 diagnosis code for billing to support the medication order.

ICD-10 Diagnosis Code: _____

Diagnosis: _____

Medication: _____ Dose: _____ Route: _____
Ex. 15 mg (not number of units/tabs)

Time during school: _____ (Example: during lunch, before lunch, before gym)
(If you must specify a time, please limit hours to 10:00 am to 1:00 pm, except pm medications.
Parents/guardians should administer before -school or after-school medications).

Intended effects: _____ Restrictions: _____

Conditions under which to administer prn medications: _____

Other medication being taken (ON REVERSE):
Indicate if you have provided additional information as an attachment or on the reverse of this form.

Date: _____ Prescriber's Signature: _____ Phone: _____

Print Prescriber's Name: _____ FAX Number: _____ NPI#: _____

The spaces below are optional. Please carefully consider the appropriateness of this request.

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: _____

PARENT PERMISSION For Independent Use and Carry

I agree that my child can use their 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.

Date: _____ Parent/Guardian Signature: _____

STUDENT ACCEPTANCE OF RESPONSIBILITY

I will carry and/or store my medication in a responsible manner. I will take it as directed and will not allow others to use the medication. I will visit the nurse once each year for an update on how things are going.

Date: _____ Student Signature: _____

PLEASE RETURN THIS FORM TO: