

Provider and Parent/Guardian Permission to Administer Medication At School/School-Sponsored Events

RETURN THIS COMPLETED FORM TO THE SCHOOL HEALTH OFFICE WHERE YOUR CHILD ATTENDS SCHOOL

To Be Completed By Parent/Guardian

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) _____

Side Effects _____ 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.

Name/Title of Prescriber (Please Print) Date

Prescriber's Signature Phone

Email

Stamp

You can find your school nurse on the [HPCSD Health Services Page](#) or by scanning this QR code.

