



PO BOX 9  
ACCORD, NY 12404  
(845) 687-2400

### HEALTH OFFICE

Joann Redmond  
RN, BSN High School  
(845) 687-2400 Ext. 4218  
Fax: (845) 377-6805

Krista Kelly, RN  
Junior High School  
(845) 687-2400 Ext. 4603  
Fax: (845) 687-7109

Alyssa O'Donnell, RN  
Intermediate School  
(845) 687-2400 Ext. 4604  
Fax: (845) 687-7109

Rita Stoddard, RN  
Kerhonkson  
Elementary School  
(845) 626-2451  
Fax: (845) 377-6808

Lauri Mulholland, RN  
Marbletown  
Elementary School  
(845) 687-0284  
Fax: (845) 377-6809

## CONTRACT FOR SELF ADMINISTRATION OF MEDICATION

Student: \_\_\_\_\_ Grade: \_\_\_\_\_ DOB: \_\_\_\_\_

Medication(s): \_\_\_\_\_

### Student Responsibilities for Carrying and Using Medication Observed:

YES NO

- |     |     |                                                                                                                                                                                                                                                            |
|-----|-----|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ___ | ___ | Student is able to:                                                                                                                                                                                                                                        |
|     |     | <ul style="list-style-type: none"><li>Identify the correct medication, identify the purpose of the medication, know the correct dosage, identify the time the medication is needed and describe what will happen if the medication is not taken.</li></ul> |
| ___ | ___ | Student demonstrates the correct use/administration of medication                                                                                                                                                                                          |
| ___ | ___ | Student does not share medication with others                                                                                                                                                                                                              |
| ___ | ___ | Student will keep medication in agreed location: _____                                                                                                                                                                                                     |
| ___ | ___ | Student will come directly to the Health Office if they have used the medication.                                                                                                                                                                          |
| ___ | ___ | Student keeps a second supply of medication in the Health Office                                                                                                                                                                                           |
| ___ | ___ | Student will arrange with coach where medication will be located during sports games/practices.                                                                                                                                                            |

The Student does demonstrate the specified responsibilities.

The Student may carry his/her medication. If the Student does not follow the above agreement, the privilege of carrying and using his/her medication may be rescinded

\_\_\_\_\_  
(Student Signature & Date)

\_\_\_\_\_  
(Nurse Signature & Date)

I will support my child to follow the above agreement and if he/she does not, I will be Contacted, and a new plan will be developed with the school nurse.

\_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_\_  
Date

**PROVIDER ATTESTATION AND PARENT PERMISSION  
FOR INDEPENDENT MEDICATION CARRY AND USE**

**Direction for the Health Care Provider:** This form may be used as an addendum to a medication order which does not contain the required diagnosis and attestation for a student to independently carry and use their medication as required by NYS Law. A **provider order** and **parent/guardian permission** are needed in order for a student to carry and use medication that require rapid administration to prevent negative health outcomes. These medications should be identified by completing the appropriate boxes below.

**Student Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Name of Medication: \_\_\_\_\_  
Dosage: \_\_\_\_\_  
Specific times to be given: \_\_\_\_\_  
School Year: \_\_\_\_\_

\_\_\_\_\_  
(Print Name of Healthcare Provider)

Stamp:

\_\_\_\_\_  
(Signature)

Date: \_\_\_\_\_

**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 required 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)

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent/Guardian 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.

**Parent/Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_