SCSD Permission to Administer Medications in School

Somers High School	Somers Middle School	Somers Intermediate School	Primrose Elementary School
MaryAnn Castro, RN	Melanie Bernardi, RN	Colleen Caron, RN	Toni Anne Hirsch, RN
914-248-8612	*914-277-4099*	*914-277-3952*	*914-248-8020*
Fax 914-931-2126	*Fax 914-992-6542*	*Fax 914-430-2136*	*Fax 914-430-2135*

Student Name: _____ **Preferred Name** _____ **DOB:** _____

Grade: _____ **School: (Please Circle)** **SHS** **SMS** **SIS** **PES**

I give permission for the below medication(s) to be administered to my child as ordered by my health care provider. I will furnish the medication in the original pharmacy container, properly labeled with directions and dosage, or original over-the-counter medication container/packaging with my child's name on it. I also give permission for Somers Central School District Health Offices to exchange information with my child's physician when their care warrants.

Parent/Guardian Signature _____**Date** _____ **Phone** _____

To Be Completed by Health Care Provider

Date	Diagnosis	Medication Name	Dosage	Route	Frequency/Time

Name and Title of Licensed Prescriber (Print & Stamp) _____

Address _____

Prescriber's Signature _____**Date** _____ **Phone** _____

***Health Care Provider Permission for Independent Use and Carry (6th - 12th Grade Only)*:**

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 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:

- ☐ Allergy and requires Epinephrine Auto-injector
- ☐ Asthma or Respiratory Condition and requires Inhaled Respiratory Rescue Medication
- ☐ Diabetes and requires Insulin/Glucagon/Diabetic Supplies
- ☐ _____which requires rapid administration of _____
  (State Diagnosis) (medication name)

Name and Title of Licensed Prescriber (Print & Stamp) _____

Parent/Guardian Permission for Independent Use and Carry

Independent Carry and Use Attestation is 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 to allow this option in school.

Schools may revoke the self-carry/ self-administer privilege if the student proves to be irresponsible or incapable. To request this option please sign below:

Parent/Guardian Signature _____**Date** _____ **Phone** _____

***This medication order is valid for the school year. Medication must be picked up at the end of the school year or be discarded**