

# **SACHEM CENTRAL SCHOOL DISTRICT**

## **Provider and Parent Permission to Administer Medication at School/School Sponsored Events**

### **To Be Completed By Parent**

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) \_\_\_\_\_

Recommendations \_\_\_\_\_ 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.

**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	Stamp
Prescriber's Signature	Phone	
Email		

### **Return to:**

School Nurse: \_\_\_\_\_ School: \_\_\_\_\_

School Address: \_\_\_\_\_

Phone: (    ) \_\_\_\_\_ Fax: (    ) \_\_\_\_\_ Email: \_\_\_\_\_