

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

Prescriber's Signature

Phone

Email

Stamp

Return to:

School Nurse: _____ School: _____

School Address: _____

Phone: () _____ Fax: () _____ Email _____

Permission to Administer Single Medication

Student Name: _____ DOB: _____

Grade: _____ Teacher/HR: _____ School: _____

To Be Completed By Health Care Provider

Diagnosis _____

Medication _____ Dose _____ Route _____ Time(s) _____

Recommendations _____ ICD Code _____

All medication should be given as close to the prescribed time as possible, however may be given up to one hour before and no later than one hour after the prescribed time. Please advise the school if there is a time-specific concern regarding administration of the medication.

Prescriber please check all that are applicable:

☐ If morning dose is not given at home, nurse may administer morning dose of _____ after verbal or written notification from parent. Please advise parent to send in additional medication

☐ Medication is required: ☐ On bus ☐ On field trips ☐ On school-sponsored after school/weekend activities/sports

☐ I assess this student to be **self-directed*** regarding this medication.

*They understand the purpose, name, amount, dose, timing, and effect of taking or not taking the medication, can recognize the medication and refuse to take it inappropriately and can ingest, inhale, apply or calculate and administer the correct dose of the medication independently.

☐ I have determined this student is consistent and responsible in taking their own medications (Self-Directed) and in addition, give them permission to **self-carry and self-administer** this medication. They will be considered independent in medication delivery and need intervention only during emergencies.

Name and Title of Licensed Prescriber (Please Print) _____

Prescriber's Signature _____ Date _____ Phone _____

To Be Completed By Parent

I give permission for the above medication 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.

Parent/Guardian Signature _____ Date _____ Phone _____

Additional Permission for Self –Administer/Self Carry (Requires Health Care Provider Consent Above)

Parent permission and provider consent is required for students to self-administer and self-carry medication. **Students with this designation are considered independent in taking their medication at school and require no supervision by the nurse.** Parents assume responsibility for ensuring that their child is carrying and taking their medication as ordered. 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 _____

School Nurse: _____ School _____

Phone: _____ Fax: _____ Email _____

SACHEM CENTRAL SCHOOL DISTRICT

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Grade: _____ Teacher/HR: _____ School: _____

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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 _____

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Name/Title of Prescriber (Please Print)

Date

Prescriber's Signature

Phone

Email

Stamp

Return to:

School Nurse: _____ School: _____

School Address: _____

Phone: () _____ Fax: () _____ Email _____

2016-17 School Year

New York State Immunization Requirements for School Entrance/Attendance¹

NOTES:

Children in a prekindergarten setting should be age-appropriately immunized. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). For grades Pre-k through 8, intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. (Exception: intervals between doses of polio vaccine need to be reviewed only for grades prekindergarten, kindergarten, 1, 2, 6, 7 and 8.) Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. Intervals between doses of vaccine DO NOT need to be reviewed for grades 9 through 12. See footnotes for specific information for each vaccine. Children who are enrolling in grade-less classes should meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements **MUST** be read with the footnotes of this schedule.

Vaccines	Prekindergarten (Day Care, Head Start, Nursery or Pre-k)	Kindergarten and Grades 1 and 2	Grades 3, 4 and 5	Grades 6, 7 and 8	Grades 9, 10, 11 and 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap) ²	4 doses	5 doses or 4 doses if the 4th dose was received at 4 years of age or older or 3 doses if aged 7 years or older and the series was started at 1 year of age or older		3 doses	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine booster (Tdap) ³	Not applicable			1 dose	
Polio vaccine (IPV/OPV) ⁴	3 doses	4 doses or 3 doses if the 3rd dose was received at 4 years of age or older	3 doses	4 doses or 3 doses if the 3rd dose was received at 4 years of age or older	3 doses
Measles, Mumps and Rubella vaccine (MMR) ⁵	1 dose	2 doses			
Hepatitis B vaccine ⁶	3 doses	3 doses or 2 doses of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years of age			
Varicella (Chickenpox) vaccine ⁷	1 dose	2 doses	1 dose	2 doses	1 dose
Meningococcal conjugate vaccine (MenACWY) ⁹	Not applicable			By Grade 7: 1 dose	Grade 12: 2 doses or 1 dose if the dose was received at 16 years of age or older
Haemophilus Influenzae type b conjugate vaccine (Hib) ⁹	1 to 4 doses	Not applicable			
Pneumococcal Conjugate vaccine (PCV) ¹⁰	1 to 4 doses	Not applicable			



Department
of Health