BALDWINSVILLE CENTRAL SCHOOL DISTRICT
29 East Oneida Street, Baldwinsville, NY 13027

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

To Be Completed By Parent

Student Name: _____ DOB: _____ Grade: _____

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. If my provider and I feel that my student can independently administer and carry their inhaler, epi-pen or diabetes supplies, I acknowledge that staff intervention and support is needed only during an emergency.

Signature: _____ Date: _____

To Be Completed By Health Care Provider – Valid for One School Year

Diagnosis: _____

Medication: _____ Dose: _____

Time: _____ Route: _____ 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 provider attestations that the student has demonstrated they can effectively self-administer **inhaled respiratory rescue medications, epinephrine auto-injector, and insulin**, carry glucagon and diabetes supplies and parent/guardian permission. Staff intervention and support is needed only during an emergency.

☐ Medication **MUST** be available during all field trips

☐ It is not necessary for student to have medication on field trip

_____ _____
Name/Title of Prescriber (Please print) **Date**

_____ _____
Prescriber's Signature **Phone**

_____
Email

Stamp