

St. Peter RC School

140 N 6th St, Lewiston, NY 14092

Main Number (716) 754-4470 • FAX (716) 754-0167

Parent & Provider Permission to Administer Medication at School/School Sponsored Events

To Be Completed By Parent Or Guardian – Valid For One (1) School Year

School Year: _____

Student Name: _____ DOB: _____

Grade: _____ Teacher/HR: _____

I authorize the school nurse or event chaperone for off-site school events to administer the medication listed on this plan. I will provide the medication in the original pharmacy or over-the-counter packaging.

Parent/Guardian Signature _____

Phone # _____

To Be Completed By Health Care Provider – Valid for One (1) School 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 the nurse if there is a time-specific concern regarding administration.

*** OPTION IN ADDITION TO ABOVE ***

(Check the box immediately below if your child is taking this option. Provider must sign below in either case.)

Independent Carry and Use Attestation (Required for Student to Self-Carry Medication)

In order for a student to independently carry and use medication in school or at a school sponsored event, NYS law requires both provider attestation (below) that the student has demonstrated he/she can effectively self-administer inhaled respiratory rescue medications, epinephrine auto-injector, and/or insulin medications, *along with* parent/guardian authorization (above) and parent/guardian delivery of medication to the school nurse in order to allow this option in school.

Health Care Provider Permission for Independent Use and Carry (Required)

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 requires *Epinephrine Auto-Injector*
- Asthma/respiratory condition and requires *Inhaled Respiratory Rescue Medication*
- Diabetes and requires *Insulin/Glucagon/Diabetes Supplies*
- _____ which requires rapid administration of _____

State Diagnosis

Medication Name(s)

Name/Title of Provider (Please Print)

Phone

Provider Signature

Date