Nanuet Union Free School District

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

TO BE COMPLETED BY PARENT/GUARDIAN

Student Name: DOB:

School: Grade and/or HR:

I request the school nurse give the medication listed on this plan. I will provide the medication in the original pharmacy or over the counter container.

Date:

Parent/Guardian Signature

TO BE COMPLETED BY HEALTH CARE PROVIDER – VALID FOR 20__ SCHOOL YEAR

Diagnosis:_____

MEDICATION	DOSAGE	FREQUENCY	ROUTE

Please note: Medication will be administered 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 here:_____

☐ **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 medication which require rapid administration along with parent/guardian permission to allow this option in school. **Check this box and attach the attestation (on page 2) to this form to request this option.**

Prescriber's Name:_____ Date:_____

Prescriber's Signature:_____ *(stamp below)*

This form should be completed <u>in addition</u> to the permission to administer medication form (see other side) and should only be filled out if you are giving permission for student to independently carry rescue medications <u>specifically outlined below</u>

PROVIDER ATTESTATION AND PARENT PERMISSIONS FOR INDEPENDENT CARRY AND USE

Directions for Health Care Provider: This form is to be used as an addendum to a medication order for a student to independently carry and use their medication. **<u>Both a provider order and parent/guardian permission are required</u>** for a student to carry and use medications that require rapid administration to prevent negative health outcomes. These medications should be identified by checking the appropriate boxes below.

Student Name:_____ DOB:_____

Health Care Provider Permission for Independent Use and Carry

I attest that this student has demonstrated to me that he or 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.

□ Allergy and requires Epinephrine Auto-injector
□ Asthma or respiratory condition and requires inhaled respiratory rescue medication
□ Diabetes and requires insulin/glucagon/diabetes supplies

Prescribers Name:

Prescriber's Signature: Date:

(stamp)

Parent/Guardian Permission for Independent Use and Carry

I agree that my child can use their medication 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.

Signature: Date: