HEALTH CARE PROVIDER ATTESTATION AND PARENT PERMISSIONS FOR INDEPENDENT MEDICATION CARRY AND USE

Directions for the Health Care Provider: This form may be used as an addendum to a medication order which does not contain the required diagnosis and attestation for a student to independently carry and use their medication as required by NYS law. A **provider order** and **parent/guardian permission** are needed in order 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: _____ Grade: _____

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 during school and school sponsored activities. 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 or respiratory condition and requires Inhaled Respiratory Rescue Medication
_____Diabetes and requires Insulin/Glucagon/Diabetes Supplies

_____ which requires rapid administration of _____
(State Diagnosis) (Medication Name)

Doctor's Name (Please Print): _____

Signature: _____ Date: _____

PLEASE 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 during school and school sponsored activities. Staff intervention and support is needed only during an emergency.

Parent/Guardian's Name (Please Print): _____

Signature: _____ Date: _____

PARENT AND HEALTH CARE PROVIDER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

Name: _____ DOB: _____ Grade: _____

A. To be completed by parent or guardian

I request my child receive the medication as prescribed below by our health care provider. The medication is to be furnished by me in the properly labeled original container from the pharmacy.

Parent/Guardian's Name (Please Print): _____

Signature (Parent or Guardian): _____ Date: _____

Cell Number: _____ Home Number: _____ Work Number: _____

B. To be completed by health care provider:

I request that my patient, as listed below, receive the following medication:

Name of Student: _____ DOB: _____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN

Duration of Treatment: _____

Possible Side Effects and Adverse reactions (if any): _____

Heath Care Provider's Name (Please Print):_____

Health Care Provider's Signature: _____ Date: _____

Address: _____ Phone: _____

PLEASE STAMP

Please return this form with the medication to the Attendance Office