Averill Park Central School District
Authorization for Administration of Medication for Grades K - 12

A. To be completed by the parent or guardian:

I request that my child _____ DOB_____, attending _____, receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse will administer the medication or an adult will supervise my child taking his/her own medication.

Signature (Parent or Guardian): _____Date: _____

Telephone: Home: _____ Work: _____ Cell: _____

B. To be completed by the licensed health care prescriber:

Name of student: _____ Date of Birth: _____

Diagnosis: _____

Name of Medication: _____

Prescribed Dosage, _____Frequency: _____

Route of Administration: _____

Time to be taken during School Hours: _____

Duration of Treatment: _____

Possible Side Effects and Adverse Reactions: _____

Other Recommendation: _____

Name of Licensed Prescriber and Title (please print): _____

Prescriber's Signature: _____ Date: _____

Phone: _____

Health Care Provider Permission for Independent Use and Carry during school and after school events

I attest that this student has demonstrated to me that they 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 with no supervision by school staff. 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)

Signature: _____ Date: _____

Parent Permission for student self-administration of medication:

I agree that my child can use their medication effectively and may carry and use this medication independently at any school/school sponsored activity with no supervision by school staff.

I assume the responsibility for monitoring my student on a daily basis to ensure that he/she is carrying and administering the medication responsibly and as prescribed. I understand that being able to carry and self- administer medication is a privilege and if my student is found to have abused that privilege, they will not be allowed to self- administer.

_____ _____

Parent Signature Date

See reverse side for more important information

Rules for Medication

Per Education Law Article 139 § 6902, licensed nurses may only administer medications consistent with orders from a duly licensed provider. http://www.op.nysed.gov/prof/nurse/article139.htm

The School Nurse is frequently asked to give internal medication such as over the counter medications or prescription drugs to children during school. Our Health Services Program functions under New York State Education law. To comply with the law, special procedures established by the State are required if a child is to receive medication during school:

The medication must be delivered directly to the School Nurse by the parent or parent's designee.

The School Nurse must have a written request on file from the family physician indicating the frequency and dosage of prescribed medication. The prescription bottle label is NOT sufficient.

The School Nurse must also have a written request from the parents on file to administer the medication as specified by the family physician.

These regulations are developed for the protection of all pupils as well as school personnel, and it is hoped that parents will recognize their need and importance in spite of the inconveniences these procedures may cause.