

# North Tonawanda City School District

7513F.1

176 Walck Road, North Tonawanda, New York 14120

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

### To Be Completed By Parent – Valid for School Year

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Grade: \_\_\_\_\_ Teacher/HR: \_\_\_\_\_ School: \_\_\_\_\_

I authorize the school nurse to administer the medication listed on this plan. I will provide the medication in the original pharmacy or over-the-counter container.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Phone #

### To Be Completed By Health Care Provider – Valid for 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 Independent Carry and Use)

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)

\_\_\_\_\_  
Name/Title of Provider (Please Print)

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Provider's Signature

\_\_\_\_\_  
Date