**NCCS HEALTH OFFICE**
**103 Rt. 276, Champlain, NY 12919**
**Middle School Nurse** Jennifer Dion, RN (518) 298-8681 Ext 3007
**High School Nurse** Kim Letourneau, RN (518) 298-8638 Ext 2406
FAX: (518) 298-2873

# PARENT AND HEALTHCARE PROVIDER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

**A. To be completed by the Parent or Guardian:**

I request that my child _____( Date of birth: _____) receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy*. I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication.

**Signature (Parent or Guardian)**: _____

Telephone: Home _____ Work _____ Date _____

**B. To be completed by the Private Healthcare 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 | ROUTE OF ADMINISTRATION |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Possible Side Effects and Adverse Reactions (if any):

**Healthcare Provider's Signature** _____ Date:_____

Address: _____ Phone: _____

* *Medication must be in original pharmacy labeled container with specific orders and name of medication.*

* *Medication and refills must be brought to school by parent, guardian or responsible adult.*

This medication order is valid for the current school year and summer school as needed.

**Double sided**

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# PROVIDER AND PARENT PERMISSIONS REQUIRED FOR INDEPENDENT MEDICATION USE AND CARRY

**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 use and carry their medication as required by NYS law. A **provider order** and **parent/guardian permission** is 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: _____**

## Health Care Provider Permission for Independent Use and Carry

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/Guardian Permission for Independent Use and Carry

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

Signature: _____ Date: _____

**Double sided**