Frontier Central School District

PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

A. To be completed by parent or guardian:

I request that my child_____DOB_____receive the medication as prescribed by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy.

B. To be completed by physician:

I request that my patient, receive the following medication:

Name of Student_____DOB_____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment:

Possible side effects and adverse reactions (if any):

Health Care Provider's Signature:_____

Name:_____
Address:_____

Signature of Parent or Guardian:_____Date_____

*****PLEASE SEE REVERSE SIDE**

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Frontier Central School District

PROVIDER AND PARENT PERMISSIONS
REQUIRED FOR INDEPENDENT MEDICATION CARRY AND USE

Directions for the Health Care Provider: This form may be used as an addendum to a medication order for a student to independently carry and use their medication as required by NYS law. 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
- ☐ Other _____ (State Diagnosis) which requires rapid administration of _____ (Medication Name)

Signature: _____ Date: _____

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 with no supervision by school staff.

Signature: _____ Date: _____

Please return to School Nurse:

School Nurse:		School:
Phone #:	Fax:	Email:

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