Frontier Central School District

Parent/Guardian Permission to Allow Another Adult to Give Medication to Their Child

To Be Completed by Parent/Guardian for Each Event Requested

Information about the Student

Name:	Grade: ☐ N/A	Teacher/HR:
School:	DOB: / /	Date:

Person (Designee) Chosen by Parent to Give the Medication(s)

Name:	Relationship:

Medication(s) To Be Given to the Student By the Designee

Medication Name Copied From Label	Dose/Amount of Medication- Copied From Label	Time Medication Should Be Given - Copied From Label

School Sponsored Event Where the Medication Will Be Given

Name of Event	Location of Event	Date of Event

- **I have included provider order and parent permission form for medications administration during school sponsored events.**
- **I permit the designee listed above to administer the medication(s) listed to my child.**
- **I will train the designee listed on how to properly give the medication and provide the medication to the designee for this event in a properly labeled container.**
- **I understand that the School or District will not be liable for any problems that may arise as a result of the administration of the listed medications) by the designee.**

Parent/Guardian Printed Name: _____ Phone: _____

Parent/Guardian Signature: _____ Date: _____

Please note: The person chosen as the designee by the parent or guardian must be in accordance with Education Law §6908: a *family member, household member or friend, or person employed primarily in a domestic capacity who does not hold himself or herself out, or accept employment as a person licensed to practice nursing.*

A separate from must be completed for each event requested.

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 medication 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 _____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 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: