Union - Endicott Central School District

ADMINISTRATION OF MEDICATION (PARENT PROVIDER AUTHORIZATION FOR ADMINISTRATION OF MEDICATION)

To be completed by the parent or guardian

I request that my child _____, DOB _____, GRADE _____, receive the medication as prescribed below by his or her physician or other licensed provider. I agree that my child requires supervision as stated below and have reviewed this plan with my child's physician or other licensed provider.

I agree to bring in the original labeled pharmacy container or over-the-counter container that is labeled with the specific name of the medication and dosing orders.

Parent/Guardian Signature: _____

Home/Work Telephone: _____ Date: _____

To be completed by physician or other licensed provider

I request that my patient, as listed below, receive the following medication:

Student: _____ DOB _____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRAION

Duration of Treatment:	

*Order may extend to a summer school session if needed [ ] Yes [ ] No

**Order may extend to additional morning dose if parent verifies it was missed [ ] Yes [ ] No

Possible Side Effects/Adverse Reactions (if any):	

PLEASE CHECK ONE:

[ ] NURSE DEPENDENT STUDENT: I deem this child to be a nurse-dependent student and understand that administration of oral, topical, inhalant and injectable medications must remain the responsibility of the school nurse, licensed practical nurse under the direction of a school nurse, physician, or parent.

[ ] SUPERVISED STUDENT: I deem this child to be a supervised student who can recognize his or her own medication, knows when and how much of the medicine he or she should be taking, and is able to refuse the wrong medication from an adult if offered. However, I would define this student as requiring adult supervision and therefore, an RN, LPN, or non-medically-licensed staff member with training from the RN may assist the student in administering his or her medication.

[ ] INDEPENDENT STUDENT: I attest that this child is an independent student who has demonstrated the skill and understanding to carry and self-administer his or her own prescribed medication(s) effectively without assistance from an adult [limited to those rescue medications prescribed for respiratory conditions, life-threatening allergies, or diabetes, or for certain other health condition(s), as determined on a case by case basis, which warrant rapid administration or prescribed medication(s)].

Provider/Title (Please Print):	Provider Signature:
Address:	Phone Number:

Parent or Guardian must submit written request to School Nurse prior to summer session.

To be completed if child is deemed an independent student:

Parent or Guardian Permission for Independent Students

I agree that my child is responsible and understands how to use his or her medication and/or testing kit effectively, and I give my permission for my child to use and carry this medication/testing kit independently at school/school sponsored activities with no routine supervision by school staff.

Name of Parent/Guardian (Please Print): _____

Parent/Guardian Signature: _____ Date: _____