AUBURN ENLARGED CITY SCHOOL DISTRICT

School Health Services

PARENT AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

To be completed by parent/guardian:
I request that my child ______________________________, grade _______, receive the medication as prescribed below by our licensed health care prescriber. 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 absence of the school nurse, will administer the medication. I hereby authorize the Auburn Enlarged City School District to release information to and receive information from the health care provider named below.

Signature Parent/Guardian ____

Address: ____

Telephone: Home ________________ Work ________________ Date ____________________

To be completed by the licensed health care prescriber:
I request that my patient, as listed below, receive the following medication:

Name of student: ____ Date of birth __________

Diagnosis: ____

Name of medication:

Prescribed dosage, frequency and route of administration: Indicate all prescribed doses during home/school hours: ____

Time to be taken during school hours: ____

Duration of treatment: ____

Possible side effects and adverse reactions (if any): __________________________________

____

Other recommendations: ____

Name of Licensed Prescriber and Title (please print): ________________________________

Prescriber's Signature: ____________________________ Date: ________________________

Address: ______________________________________ Phone: _______________________

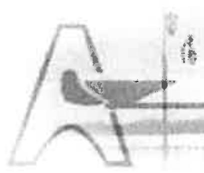
Dear Parents or Guardians, Date:

A new New York State law allows students with **respiratory(breathing) conditions, allergies, and/or diabetes the right to independently carry and use their inhaled respiratory rescue medications; epinephrine auto-injectors; and insulin, glucagon, and related diabetes supplies** if the following is provided to the school:

1. written permission from the parent/guardian; and
2. written provider order with an attestation stating both the diagnosis, and that the student has demonstrated they can effectively administer the medication(s).

Independent carry and use of medications means that your child will take their own medicine without any help. The school will not know if your child takes their medicine. If you want your child to independently carry and use a medication listed above during the school day or at school sponsored events, you will need to ask their health care provider to put in writing (attest), that they have watched your child use the medication correctly. We may ask you to have your provider write another order with the required information if it not on the medication order you bring to school.

After review by our medical director, students with other health conditions who need medications quickly during the school day or at school sponsored events may also be given permission to independently carry and use their medications if they provide the same written notes.



Auburn Enlarged City School District

Working together ... Building a community of Learners

PROVIDER ATTESTATION 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 which does not contain the required diagnosis and attestation for a student to independently carry and use 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. 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 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 carry and use this medication independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency.

Signature: ______________________________ Date: ________________

Please return to School Nurse: