AUGUSTINIAN ACADEMY

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Permission to Administer Single Medication

Student Name: _____ DOB: _____ Grade: _____

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To Be Completed by Health Care Provider (All parts must be completed):

Diagnosis _____

Medication _____

Dose _____ Route _____ Time(s) _____

Recommendations/side effects _____

Health Care Provider Permission for Independent Use and Carry:

NYS law requires provider attestation to allow students to self-carry and administer their own emergent medications during school hours including, but not limited to Epinephrine Auto Injectors, Inhalers, Diabetes Medication & Supplies or ANY medications on field trips.

Prescriber Initials _____

I **attest** that this student has demonstrated to me that they can self-administer the medication listed above 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.

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Name of Licensed Prescriber (Print) _____

Title _____ Phone _____

Prescriber's Signature _____ Date _____

***This order is valid for one (1) school year: _____-_____.

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Parent Permission for School Staff to Administer Medication:

I request the school nurse give the medication listed on this plan; or after the nurse determines my child can take their own medications; trained staff may assist my child to take their own medications. I will provide the medication in the original pharmacy or over the counter container. I understand that a parent/guardian is required to bring this medication to school and deliver it to the school nurse directly (unless provider permission for self-carry has been given). This plan will be shared with school staff caring for my child.

Parent/Guardian Signature _____ Date _____ Phone _____

Additional Parent Permission for Independent/Self 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.

Parent/Guardian Signature _____ Date _____

Reviewed by: _____

Date: _____

Please return this form to the school nurse.

Revised 10/2018