BRENTWOOD UNION FREE SCHOOL DISTRICT

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOLS AND AFTER SCHOOL ACTIVITIES

INSTRUCTIONS TO PARENT/GUARDIAN: According to New York State law, medication, including non-prescription (over the counter) products, **WILL NOT** be administered in school UNLESS **THE FOLLOWING ARE PROVIDED:**

1. Section A: A written order from a licensed prescriber for any and all products described below
2. Section B: A written statement from the parent or guardian requesting administration of the medication in school as ordered by the licensed prescriber
3. The parent or guardian must assume responsibility to have the product delivered directly to the health office in a properly labeled original container
4. Indication of ability for independent Use and Carry by MD and parent signatures

A. PHYSICIANS'S PERMISSION FORM: *Please complete all sections in Part A*

Student: _____ Date of Birth: _____ Diagnosis: _____ ICD-10: _____

Medication: _____

Dosage and Times Given: _____

Side Effects, if any _____

Duration: _____ Other recommendations? _____

☐ Medication can be suspended for a field trip lasting no more than one day

Select option for this student:

☐ Nurse Dependent: Nurse must administer

☐ Supervised Student: Student self-administer under supervision

☐ INDEPENDENT: compete box below

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)

Prescriber's Signature: _____ STAMP:

Prescriber's Phone Number: _____ DATE: _____

B. PARENT/GUARDIAN PERMISSION (REQUIRED)

I hereby request that the nurse administered such medication during the school day as prescribed by the above health care provider. This medication is to be administered as ordered during the present school year, or until terminated by written notice. We release the nurse and the **BUFSD** of any liability relative to the administration and/or reaction of the medication on the above named student.

I request that my child be permitted to carry/self-administer his/her medication at school and school sponsored activity if **the MD has indicated permission above**. I understand it is my responsibility to monitor my child on an ongoing basis to insure that he/she is carrying and taking medication as ordered. Staff intervention and support is needed only during an emergency.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

PHONE NUMBER: _____ Student Grade: _____