Mayfield CSD Health Services

High School: Janine Kilpatrick R.N.518- 661-8211 Elementary School: Rebecca Lestage R.N. 518-661-8254

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 which does not contain the required diagnosis and attestation 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 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 with no supervision by school staff.

Signature: _____ Date: _____

Please fax form to the appropriate Health Office:

High School: 518-661-7666 Elementary School: 518-661-6590

*************DOUBLE SIDED FORM********

Mayfield CSD Health Services

High School: Janine Kilpatrick R.N.518- 661-8211 Elementary School: Rebecca Lestage R.N. 518-661-8254

Provider and Parent Permission to Administer Medication at School/School Sponsored Events

To Be Completed By Parent

Student Name: _____ DOB: _____

Grade: _____ Teacher/HR: _____ School: _____

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 on field trips or in the event that the nurse is unavailable. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with school staff caring for my child.

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Email **Phone Where We Can Reach You** ☐ **Check if Cell**

To Be Completed By Health Care Provider-Valid for 1 Year

Diagnosis _____

Medication _____

Dose _____ **Route** _____ **Time(s)** _____

Recommendations_____ **ICD Code** _____

Note: Medication will be given as close to the prescribed time as possible, but may be given up to one hour before or after the prescribed time. Please advise if there is a time-specific concern regarding administration.

☐ **Independent Carry and Use Attestation Attached (Required for Independent Carry and Use)**

NYS law requires both provider attestation that the student has demonstrated they can effectively self- administer inhaled respiratory rescue medications, epinephrine auto-injector, Insulin, carry glucagon and diabetes supplies or other medications which require rapid administration along with parent/guardian permission delivery to allow this option in school. Check this box and attach the attestation to this form to request this option.

_____ _____ **Stamp**

Name/Title of Prescriber (Please Print) **Date**

_____ _____

Prescriber's Signature **Phone**

******PLEASE NOTE OVER THE COUNTER MEDICATIONS (Tylenol, Advil, cold medication, etc.) ARE NOT TO BE SELF DIRECTED AND MUST BE KEPT AND TAKEN IN THE HEALTH OFFICE!***

******DOUBLE SIDED FORM******