SYRACUSE CITY SCHOOL DISTRICT

Pamela J. Odom, Superintendent of Schools

Health Services

REQUEST FOR ADMINISTRATION OF MEDICATION DURING THE SCHOOL DAY

Student Name: _____ School: _____

Home Address: _____ Grade: _____

Dear parent/guardian:

Every effort should be made to administer medication at home, as it does represent a disruption in the student's school day. However, if your physician feels that medication is necessary during the school day, please submit this completed form before medication is sent to school.

A new form must be filled out for each change of medication or dosage and renewed each school year. State law does permit administration of medication during the school day only with written directions from the physician and parent. In some instances, approval by the school physician may be required.

Dr. Ted J. Triana, D.O., SCSD Medical Director

To Be Completed by Parent/Guardian

- I request the school nurse give the medication, specified below, to my student named above.
- Once it is determined my student can take their own medications, trained staff may assist my child with their medications on field trips or in the absence of a school nurse.
- I will supply the school nurse with the medication in the original container, or duplicate professionally labeled by the pharmacist for this purpose.

Parent/Guardian Signature: _____ Date: _____

Relationship to Student: _____ Phone Number: _____

To Be Completed by Health Care Provider
Valid for 1 Year or Until The End of Summer School

Diagnosis: _____

Medication: _____

Dose: _____ Route: _____ Time(s): _____

Side Effects to Expect: _____

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.

☐ **Trained Staff** may assist this student with medication on a field trip or in the absnce of a school nurse

☐ **Independent Carry and Use Attestation (See reverse side, this form is required for Independent Carry and Use)**

Provider's Signature: _____ Date: _____

Phone Number: _____ Provider's Stamp: _____

Please return to School Nurse

Health Services

PROVIDER AND PARENT PERMISSION 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 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: _____ **D.O.B:** _____

Health Care Provider Permission for Independent Use and Carry

I attest 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

☐ Other: _____ which requires rapid administration of _____
Diagnosis Medication

Signature: _____ Date: _____

Parent/Guardian Permission for Independent Use and Carry

I agree that my child ca use their medication effectively and may carry and use this medication independently at any school or school sponsored activity with no supervision by school staff.

Signature: _____ Date: _____

Please return to School Nurse:

School Nurse: _____ School: _____

Phone Number _____ Fax: _____ Email: _____