SYRACUSE CITY SCHOOL DISTRICT
Health Services

Anthony Q. Davis, Superintendent of Schools

REQUEST FOR ADMINISTRATION OF MEDICATION DURING THE SCHOOL DAY

Student's Name: _____ **Grade:** _____

Home Address: _____ **School:** _____

Dear Parent or 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 by my child's medical provider, to my child named above.
- Once it is determined your child 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 Relationship

_____ _____

Date 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 absence of a school nurse.

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

NYS law requires both provider attestation (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.

_____ _____

Provider's Signature Provider Stamp

_____ _____

Date Telephone

Please return to the school nurse

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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. 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 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 return to School Nurse:

School Nurse:		School:
Phone #:	Fax:	Email: