



NORTH COLONIE CENTRAL SCHOOL DISTRICT

91 Fiddlers Lane
Latham, NY 12110-5349

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Any medication, **including** non-prescription (over the counter) medications, which are necessary to maintain the student in school, will be administered by the school nurse or designated personnel and may not be administered unless the following requirements are met:

1. **ALL** medications (prescription and non-prescriptions) **must** be prescribed by a licensed prescriber. The school nurse must have a written request from the prescriber that indicated the child's name, drug name, frequency, dosage, date prescribed, and prescribers signature. **THE PHARMACY LABEL DOES NOT CONSTITUTE A WRITTEN ORDER AND CANNOT BE USED IN LIEU OF A WRITTEN ORDER.**
2. A written parental/guardian statement requesting administration of the medication prescribed.
3. The medication needs to be delivered to the school by the parent/guardian in a properly labeled container. Prescription drugs are to be in the prescription container, properly labeled. Non-prescription medications must be in the original container/package with the student's name attached.
4. All medications must be renewed annually, and expire at the end of the present school year.

These requirements are issued by the State Department of Education, and if they are not met.....
the student will not receive his/her medication.

A. TO BE COMPLETED BY PARENT OR GUARDIAN:

I request that my child _____, in grade _____, receive the medications prescribed below by our licensed health care prescriber. I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication. **I understand that I must bring this medication into school initially and with each refill or dosage change.** If there is a dosage change I know I must have the physician write a new prescription accordingly for school.

Signature (Parent/Guardian): _____ Date: _____

Address: _____

Telephone: Home: _____ Work: _____

B. TO BE COMPLETED BY THE LICENSED HEALTH CARE PROVIDER:

I request that my patient, as listed below, receive the following medication: Date _____

Name of Student: _____ Date of Birth: _____

Diagnosis: _____ ICD Code _____

Name of Medication: _____

Prescribed Dosage, Frequency, and Route of Administration: _____

Time to be taken during school hours: _____ Duration of Treatment: _____

STUDENT MAY CARRY OWN MEDICATION: Yes, child may carry own meds. May have on the bus
(** only emergent medications / non emergent must stay in the health office) **OR at before/after school**

Possible Side Effects and Adverse Reactions (If Any): _____

Other Recommendations: _____

C. NAME OF LICENSED PRESCRIBER AND TITLE (Please Print): _____

Signature of Prescriber: _____ License # _____ NPI# _____

Address: _____ Phone: _____

10/14 DJD/updated 6/16
App KSG 6/18

***** **SEE BACK** *****

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 (** only emergent medications / non emergent must stay in the health office) 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 of licensed prescriber: _____ License # _____