**Authorization for Medication Administration**

**School- Year 2024-2025**

**To be completed by MEDICAL PROVIDER:**

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

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **MEDICATION** | **INDICATION** | **POSSIBLE ADVERSE EFFECTS** | **DOSE** | **FREQUENCY/TIME** | **DURATION** | **ROUTE** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

* **Check box if medication orders may be applied to summer school following current school year.**

**To be completed by MEDICAL PROVIDER. PLEASE CHECK ONE:**

\_\_\_\_\_\_ I understand that the **Independent Student** may self-carry and self-administer rescue medications for respiratory conditions, allergies, or diabetes without school staff assistance with a provider order and parent consent.

I understand that the school nurse, or other trained school staff, may assist with administration of the medication, including during field trips, to the **Supervised Student.**

I understand that administration of medication to the **Nurse Dependent Student** must remain the responsibility of an appropriate licensed medical professional authorized to administer medications in NYS.

**Physician’s Signature:** Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Name (Printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:

Phone:

**To be completed by PARENT/GUARDIAN:**

I request that my child DOB receive the medication as prescribed below by our medical provider. (The medication is to be furnished in the original, properly labeled container from the pharmacy).

Signature (**Parent/Guardian**): Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: (Home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Work) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Medication must be in original pharmacy labeled container with specific orders and name of medication.**

**\*Medication and refills must be brought to school by a parent/guardian, or responsible adult.**

**Nurse Verification of Independent / Supervised Students**

**To be completed by SCHOOL NURSE:**

Date:

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Teacher:

Medication: Dose: Time:

Reason for Medication:

THIS STUDENT:

|  |  |  |
| --- | --- | --- |
| **Recognizes his/her medication**  *Comments:* | **YES** | **NO** |
| **Knows how much medication he/she takes**  *Comments:* | **YES** | **NO** |
| **Knows what time his/her medication is needed during the school day**  *Comments:* | **YES** | **NO** |
| **Knows why he/she takes this medication**  *Comments:* | **YES** | **NO** |
| **Knows what happened when he/she doesn’t take their medication**  *Comments:* | **YES** | **NO** |
| **Knows when to refuse to take his/her medication when appropriate**  *Comments:* | **YES** | **NO** |

🞎 **This student DOES meet the criteria to be determined as Independent/supervised.**

🞎 **This student DOES NOT meet the criteria needed to be determined as Independent/supervised**

Plan to assist student in becoming Independent:

School Nurse Signature: Date: