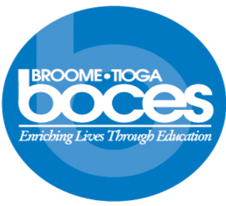


Ed Center 607-763-3411 Fax 607-763-3363
West Learning Center 607-786-2021 Fax 607-748-8616
East Learning Center 607-762-6408 Fax 607-762-6407

Authorization for Medication Administration
School Year 2022-2023

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.**

Physician's Signature: ____ Date: __________________
Physician's Name (Printed): ____
Address: ____
Phone: ____

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.**

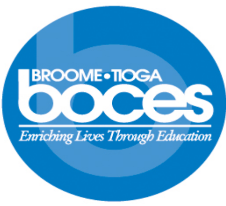
_______ I understand that administration of medication to the **Nurse Dependent Student** must remain the responsibility of an appropriate licensed medical professional authorized to administer medications in NYS.

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.**



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Nurse Verification of Independent 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.**

☐ **This student DOES NOT meet the criteria needed to be determined as Independent.**

Plan to assist student in becoming Independent: ____

____

____

School Nurse Signature: ____ Date: _______________