Avon Central Schools

191 Clinton Street · New York 14414-1495 (585) 226-2455

PARENT AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL
Prescription and/or Non-Prescription Medication

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

Name of Student_____ Date of Birth _____ Diagnosis _____

Name of medication_____

Dose_____ Frequency _____Route_____ Time taken at school: _____

Possible side effects (if any)_____

Special Instructions _____

This Medication will be available for the following:

☐ Bus ☐ Field Trips ☐ School Sponsored Activity ☐ In School

The student is capable of being able to be:

☐Needs Supervision ☐ Independent Carry & Use

If the usual morning dose given at home has been forgotten, the nurse may administer it at school **AFTER** verbal or written notification from the parent.
MEDICATION: _____Frequency: _____ Route_____ Dose _____

Then administer the second dose as follows: _____hrs. later OR _____No change in time

☐ **Independent Carry & Use Attestation** (Required for Independent Carry & Use):
NYS law requires both provider attestation that the student has demonstrated they can effectively self-administer inhaled respiratory rescue medications, epinephrine auto-injector, and insulin, carry glucagon and diabetes supplies and other medications which require rapid administration along with parent/guardian permission delivery to allow this option in school. Please check box if this applies for your patient.

NOTE: Prescription medication must be in the **properly labeled original container** from the pharmacy. Non- prescription (over the counter) medications must be in the **original** manufacturer's container with the child's name affixed to the container. The same applies to drug samples.

SIGNATURE OF HEALTH CARE PROVIDER: _____ DATE _____

PRINTED NAME OR STAMP OF HEALTH CARE PROVIDER_____ PHONE _____

ADDRESS: _____ FAX _____

My signature constitutes permission for the school to contact my healthcare provider regarding this form/diagnosis. I understand that the school nurse or unlicensed assistive personnel in the case of the absence of the nurse will administer the medication. I understand that the medication will **NOT** be accepted if it is not provided in the original labeled container. Further more if my child were to attend on off site school event I will accompany him/her, or designate someone to administer the medication. I give permission for the school nurse to share information with school staff on a need to know basis for my child's health and safety. I further acknowledge the Avon Central School District will not be liable for any problems that may arise as a result of the administration of such medication by the health office personnel.

FIELD TRIP: In the event your child is to attend a field trip sponsored by the school district I designate _____ to administer the scheduled medication as prescribed. As the parent/guardian I will provide such medication to the designee. This will remain in effect through the school year unless changed by the parent/guardian.

Signature (parent/guardian): _____ DATE _____