Cardinal O'Hara HIGH SCHOOL

Provider and Parent Permission to Administer Medication at School/School Sponsored Events

Student's Name: _____DOB :___/___/___

Grade: _____ Teacher/HR:_____ School: Cardinal O'Hara High School

I request the school nurse give the medication listed on this plan; or after the nurse determines my child can take their own medications, trained staff may assist my child to take their own medications. I will provide the medication in the original pharmacy or over-the-counter container. This plan will be shared with school staff caring for my child.

_____ _____
Parent/Guardian Signature Date

_____ _____
E-Mail Phone # where you can be reached

To Be Completed by Health Care Provider – Valid for One Year

Diagnosis: _____

Medication: _____

Dose: _____ Route: _____ Time(s): _____

Recommendations: _____ ICD Code: _____

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.

☐ **Independent Carry and Use Attestation Attached (required for Independent Carry and Use)**

NYS law requires both provider attestation that 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 to allow this option in school. Check this box and attach the attestation to this form to request this option.

_____ _____
Name/Title of Prescriber (please print) Date

_____ _____
Prescriber's Signature Phone Number

_____
E-Mail Address

STAMP

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Cardinal O'Hara HIGH SCHOOL

PROVIDER ATTESTATION AND PARENT/GUARDIAN PERMISSION FOR INDEPENDENT MEDICATION CARRY 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** are 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 that this student has demonstrated to me that he or she 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. Staff intervention and support is needed only during an emergency. This order applies to the medications checked below:

The student is diagnosed with:

- ☐ *Allergy and requires Epenephrine Auto-Injector*
- ☐ *Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication*
- ☐ *Diabetes and requires Insulin/Glucagon/Diabetes Supplies*
- ☐ _____ *(state diagnosis)*

which requires rapid administration of _____ *(name of medication)*

Health Care Provider Signature: _____ Date: _____

Parent/Guardian Permission for Independent Use and Carry

I agree that my child can use his/her medication effectively and may carry and use this medication independently at any school/school-sponsored activity. Staff intervention and support is needed only during an emergency.

Parent/Guardian Signature: _____ Date: _____