DeRuyter Central School

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Charles W. Walters Superintendent | *Dr. Sarah Stack Feinberg* 6-12 Principal/PK-12 Professional Development | *Kimberly O'Brien* Pre-K - 5 Principal/PK-12 Curriculum Development | *Guy Linton* Director of Special Education | *James Southard* Business Administrator

Medication Administration in School Authorization Form

Please complete this entire form.

To be completed by the licensed healthcare provider:

I request that my patient receive the following medication: Date of Birth: _______________

Student Name: ____ Allergies: __________________

Diagnosis: ____ Weight: _________________

Name of Medication: ____

Dosage: _____________ Frequency: _________________ Route of Administration: ___________________

Time to be taken during school: ___________________________ Duration of treatment: ___________________________

Possible side effects/adverse reactions: ____

❑ If am dose is missed at home, nurse may administer the am dose after verbal/written notification from parent.

❑ Medication is required: ❑ On bus ❑ On field trips ❑ At school-sponsored after school/weekend activities/sports

❑ I asses this student to be self-directed* regarding this medication.

*The student understands the purpose, name, amount, dose, timing and effect of taking or not taking the medication, can recognize the medication and refuse to take it when appropriate and can ingest, inhale, apply or calculate and administer the correct dose of the medication independently.

❑ I have determined this student is consistent and responsible in taking their own medication (self-directed) and in addition, given this student permission to **self-carry and self-administer** this medication. This student will be considered independent in medication delivery and need intervention only during emergencies. This student had been educated in the proper administration of this medication.

Licensed Prescriber's Signature: ____ Date: ______________

Print Name: ____ Phone Number: ___________________

Address: ____ Fax Number: ______________________

To be completed by parent:

I give permission for, and request that, the above medication be administered to my child as ordered by my health care provider. I will furnish the medication in the original pharmacy container, properly labeled with directions and dosage, or original over-the-counter medication container/packaging with my child's name on it.

Parent/Guardian Signature: ____ Date: _______________

Print Name: _____________________________________ Address: __________________________________

Phone Number: __________________________________ __________________________________

Additional Permission for Self-Administer/Self-Carry (Requires Health Care Provider Consent Above)

Parent permission and provider consent is required for students to self-administer and self-carry medication. **Students with this designation are considered independent in taking their medication at school and require no supervision by the nurse.** Parents assume responsibility for ensuring that their child is carrying and taking their medication as ordered. DeRuyter Central School may revoke the self-carry/self-administer privilege if the student proves to be irresponsible or incapable. I request that my child be permitted to self-carry and self-administer the above noted medication.

Parent/Guardian Signature: ____ Date: _______________

Board of Education: Fred Lawrence, President; Amy Sperat, Vice President; *Members* - Brandi Compton, Dean Hathaway, Bradley Mierke