PLAINVIEW – OLD BETHPAGE CENTRAL SCHOOL DISTRICT

PARENT AND HEALTHCARE PROVIDER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

A. To be completed by the Parent or Guardian

I request that my child _____ DOB: _____ receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy*. I understand that the school nurse or her designee in the event of her absence will assist the child.

Signature (Parent or Guardian): _____ Date: _____

Telephone: Home: _____ Work: _____ Cell: _____

B. To be completed by the Private Healthcare Provider:

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

Name of student: _____ DOB: _____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/ TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Possible Side Effects and Adverse Reactions (if any): _____

Prescriber's Signature & Stamp: _____ Date: _____

Address: _____ Phone: _____

** Medication must be in original pharmacy labeled container with specific orders and name of medication.*
** Medication and refills must be brought to school by parent, guardian or responsible adult.*

This medication order is valid for the current school year and summer school as needed.

Plainview - Old Bethpage Central School District

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 is needed, for a student to carry and use medications that requires rapid administration to prevent negative health outcomes.

Student Name: _____ **DOB:** _____

*** Form MUST be fully completed to be accepted***

Health Care Provider Permission for Independent Use and Carry

I attest that this student has demonstrated to me that they 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 only the medications checked and listed below.

❑ Allergy to:_____ & requires EpiPen/Auvi-Q.
If Benadryl is required, it must be kept in health office and ordered separately below**

❑ Asthma/Respiratory condition & requires Inhaled Respiratory Rescue Medication taken (List medication & exact directions): _____

Physician Signature and Stamp: _____ Date: _____

Complete this section for Benadryl Order Only – Must be completed by a Physician

Benadryl must be kept and administered in health office as prescribed: _____
_____

Physician Signature and Stamp: _____ Date: _____
_____

Parent/Guardian Permission for Independent Use and Carry

I agree that my child can use their 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 Signature: _____ **Date:** _____

Please return to School Nurse