**UNION SPRINGS CENTRAL SCHOOL**

**PARENT AND PHYSICIANS AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_ Grade:\_\_\_\_\_\_\_\_

**To Be Completed By Health Care Provider**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication Name** | **Dose** | **Route** | **Time** | **🗹 applicable boxes below** |
|  |  |  |  | 🞏 AM \_\_\_\_\_\_\_\_ 🞏 Bus 🞏 FT 🞏 SSA🞏Self-Directed 🞏 Self Admin-Self Carry |
|  |  |  |  | 🞏 AM \_\_\_\_\_\_\_\_ 🞏 Bus 🞏 FT 🞏 SSA🞏Self-Directed 🞏 Self Admin-Self Carry |
|  |  |  |  | 🞏 AM \_\_\_\_\_\_\_\_ 🞏 Bus 🞏 FT 🞏 SSA🞏Self-Directed 🞏 Self Admin-Self Carry |

**DIAGNOSIS:\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Prescriber please use codes below for each medication ordered:**

|  |  |
| --- | --- |
| **AM**  | Nurse may administer missed morning dose indicated after verbal or written notification from parent. Please advise parent to send in additional medication |
| **Bus**  | Medication must be available on bus  |
| **FT** | Medication is needed on field trips  |
| **SSA** | Medication is needed school sponsored extra-curricular activities |
| **Self – Directed\***  | I assess this student is self-directed regarding their medication. They understand the purpose, name, amount, dose, timing, and effect of taking or not taking the medication, can recognize the medication and refuse to take it inappropriately and can ingest, inhale, apply or calculate and administer the correct dose of the medication independently. |
| **Self-Administer****Self-Carry Students With Epi-Pens, Inhalers ONLY** | I have determined this student’s health problems are severe enough and that he/she is consistent and responsible in taking their own medications (Self-Directed) and in addition, give them permission to self- carry and self-administer this medication. **They will be considered independent in medication delivery and need intervention only during emergencies.\*** |

**Name and Title of Licensed Prescriber (Please Print)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Prescriber’s Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date** \_\_\_\_\_\_\_\_\_\_\_\_ **Phone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To Be Completed By Parent**

I give permission for the above medication (to be administered to my child) **OR** (administered by my child if self- administer only) 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** \_\_\_\_\_\_\_\_\_\_\_\_ **Phone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Self-Administer/Self-Carry ( for Students w/ Epi-Pen, Inhalers ONLY)**

Parent permission and provider consent is required for students to self-administer and self-carry medication. Students with this designation have health problems severe enough to be considered independent**\*(see above** **)** in taking their medication at school/affiliated school events and require no supervision by the Nurse/Advisor. Parents assume responsibility for ensuring that their child is carrying and taking their medication as ordered. Schools may revoke the self-carry/ self-administer privilege if the student proves to be irresponsible or incapable. To request this option please sign below:

**Parent/Guardian Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_ **Phone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_have cleared the above mentioned student to **Self-Carry/Self-Administer**  his/her

medication( s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Student has appropriately met the \***Self- Directed Criteria** as defined above**,**

 Parent Notified on:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Notified on:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Revised June 2015 **­­­­­­**