Blessed Sacrament School
Health Services

To Be Completed by Parent

Student Name: _____

DOB: _____ Grade: _____ Teacher: _____

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 Relationship

_____ _____
Date Phone Where We Can Reach You ☐ Check if Cell

To Be Completed by Health Care Provider-Valid for 1 Year

Diagnosis: _____

Medication: _____

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

Side Effects to expect:_____

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.

☐ **Trained staff may assist this student with medication on a field trip or in the absence of the school nurse**

☐ **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 delivery to allow this option in school**. Check this box and fill out the other side of this form.**

_____ _____
Providers Signature Provider's Stamp

_____ _____
Date Telephone Number

PLEASE RETURN TO THE SCHOOL NURSE

No child at any time, should have any medication, of any kind, whether prescription or over the counter, in their lunch box, backpack or any other container without school knowledge

Blessed Sacrament School ■ 3129 James Street ■ Syracuse, New York 13206 ■ 315-463-1261 ■ Fax 315-463-0253

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PROVIDER AND PARENT PERMISSIONS REQUIRED FOR INDEPENDENT MEDICATION CARRY AND USE

Directions for 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 and required by NYS law. A **provider order** and **parent/guardian permission** is 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:

Health Care Provider Permission for Independent Use and Carry

I attest 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 delivery device id needed) independently at any school/school sponsored activity with no supervision by school staff. This order applies to medications checked below.

This student is diagnosed with:

- ☐ Allergy and requires Epinephrine Auto-injector
- ☐ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication
- ☐ Diabetes and requires Insulin/Glucagon/Diabetes Supplies
- ☐ _____which requires rapid administration of_____
  (State Diagnosis) (Medication Name)

Signature: _____ Date: _____

Parent/Guardian Permission for Independent Use and Carry

I agree that my child can use medication effectively and may carry and use this medication independently at any school/school sponsored activity with no supervision by school staff.

Signature: _____ Date: _____

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