CHENANGO VALLEY CENTRAL SCHOOL

Health Office Phone: 762-6913 * Fax: 762-6897

Permission to Administer Medication

To Be Completed By Health Care Provider

STUDENT NAME: _____ **DOB:** _____ **GRADE:** _____

Medication Name	Dose	Route	Time	Diagnosis	☑ applicable boxes below
					☐ Independent Use and Carry
					☐ Independent Use and Carry
					☐ Independent Use and Carry

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 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.

_____

(Prescriber's Signature)

_____

(Prescriber's Phone)

Date: _____

Name and Title of Licensed Prescriber (Please Stamp or Print)

To Be Completed By Parent

I request that _____ receive the medication as prescribed above.

(Student's Name)

1. **Parent/Guardian will deliver the medication personally to school. Medicine will only be accepted in its original container. Medication orders must be renewed annually or when there is a change in dosage.**
2. **For prescription medicines, ask your pharmacist for a "double label."**
3. **Only an adult may bring and pick-up medicine, this is a safety issue and is school policy.**
4. **All medication must be picked up by a parent or responsible adult when it is discontinued or at the end of the school year. All medication left will be discarded by the School Nurse at the end of the school year.**
5. **It is a violation of school rules for students to carry any type of medication unless approved by the School Nurse. Therefore, sending in medications with your child can subject him/her to discipline.**
6. **If your student uses an inhaler and plays a sport they need to have one inhaler for the Health Office and one for the coach.**
7. **I understand that the school nurse or other designated person in the case of the absence of the school nurse will administer the medication.**
8. **I agree that if the Dr. indicates above independent use and carry 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.**

I have read and understand the above procedure for my child to receive medicine in school. I understand this applies to all medicine, including over-the-counter medicines such as Tylenol, Ibuprofen, cough drops and cold remedies.

Parent/Guardian Signature _____ **Date** _____ **Phone** _____