JF Kennedy Catholic Authorization for Medication Administration

Medication of any kind (prescription and/or over the counter) cannot legally be dispensed to any child in school without a health care provider's order and written parental/guardian consent. Medication must be in the original pharmacy labeled container with specific orders and brought in by an adult unless self-carry status is indicated. Medications that can be taken at home before or after school should be arranged in this manner.

Request for Administration of Student Medication in School

Student Name _____Date of Birth _____/_____/_____

I request that my child, _____ grade_____ receive the medication prescribed below by our licensed health care provider. The medication is to be furnished by me in the properly labeled original container from the pharmacy. The school nurse may contact the prescriber as needed.

Parent/Guardian Signature _____ Date_____

Print Parent/Guardian Name_____ Telephone Number: _____

TO COMPLETED BY & HEALTH CARE PROVIDER

Diagnosis_____

Name of Medication_____ Dosage Amount_____

Time medication is to be administered_____ Route _____

Duration of Treatment _____ Expiration Date of Treatment_____

Possible adverse reaction or side effects_____

Physician's Signature_____ Date_____

Physician's Stamp and/or Name or STAMP_____
Address:_____
Phone: _____

Provider and Parent Permissions Required for Independent Medication Carry and Use

(formerly self-administer and/or self-carry) Please complete the section below & sign if applicable.

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 or school sponsored activity. Staff intervention and support is needed only during an emergency. This order applies to the medications checked below;

This student is diagnosed with:

☐ Allergy and requires Epinephrine Auto-injector or other _____
☐ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication _____
☐ Diabetes and requires Insulin/Glucagon/Diabetes Supplies _____
☐ Other _____ which requires rapid administration of _____
(State Diagnosis) *(Medication Name)*

MD Signature: _____ Date: _____

Parent/Guardian Permission for Independent Use and Carry *(parent must sign for order to be valid)*

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/Guardian Signature: _____ Date: _____

This medication order is valid for the school year. Medication must be picked up at end of the school year or it will be discarded.

MEDICATION ORDER(S) MAY BE FAXED TO: Fax # 914-232-3416 Attention: *School Nurse*