VALLEY STREAM UNION FREE SCHOOL DISTRICT NO. 24

75 HORTON AVENUE VALLEY STREAM, NEW YORK 11581-1499 (516) 434-2830 FAX: (516) 256-0169

Provider and Parent Permission to Administer Medication at School/School Sponsored Events

To Be Completed By Parent

Student Name: ______________________________ DOB: ______________

Grade: _____ Teacher/HR: ________________________ School: ________________

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. **(Please attach a small photo of your child to this form.)**

______________________________ ______________

Parent/Guardian Signature **Date**

______________________________ ______________________________

Email **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) ______________

Recommendations________________________________ ICD Code ____________

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.

Prescriber please check all that are applicable:

☐ If morning dose is not given at home, nurse may administer morning dose of________________________ after verbal or written notification from the parent. Please advise parent to send in additional medication

☐ Medication is required: ( ) on field trips

☐ **I assess this student to be self directed* regarding this medication**

*The student understands the name, purpose, amount, dose, timing and effect of taking or not taking the medication; can recognize the medication and refuse to take it if it is the wrong medication; can ingest, inhale, apply or calculate and administer the correct dose of the medication independently.

______________________________ ______________

Name/Title of Prescriber (Please Print) **Date**

______________________________ ______________

Prescriber's Signature **Phone**

Stamp

Return to: Mrs. Estelle Dempsey, RN
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