Pittsford Central School District

Permission to Administer Medications in School Sponsored After School and Weekend Activities/Sports

TO BE COMPLETED BY THE STUDENT'S PHYSICIAN ANNUALLY

Student _____ Date of Birth _____

Medication _____ Dose _____ Route _____ Time(s) _____

Purpose_____ Side Effects_____

I. All medications should be given as close to the prescribed time as possible, however may be given up to one hour before and no later than one hour after the prescribed time. Please advise the school if there is a time-specific concern regarding administration of the medication.

Physician please check if applicable:

☐ If morning dose is missed at home, RN may administer **morning dose of** _____ with parent permission.
☐ Medication **should** be taken on field trips.
☐ Medication **should** be given during school sponsored after school and/or weekend activities/sports.

Physician's Signature _____ **Date** _____

Physician's Name (Please Print) _____ **Phone** _____

I give permission for the above medication to be administered to my child as ordered by my health care provider and for the school nurse to share information with physician regarding this medication.

Parent's Signature _____ **Date** _____

II. **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/school sponsored activity. Staff intervention/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
❑ 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)

Physician's Signature: _____ Date: _____

III. A student may self-carry if:

1. The student is in grades 6-12. An exception to this rule is when the medication Lactaid, which younger students could carry.
2. The medication is **not:** a controlled substance, psychotropic, for ADHD, or contains dextromethorphan (DMX) or stimulant decongestants.
3. An assessment by the school nurse confirms that the student is self-directed to carry and self-administer her/his medication properly.
4. Parent assumes responsibility for insuring that his/ her child is carrying and taking the medication as ordered.

I give permission for this student to self-carry and self-administer the above medication as I consider her/him responsible. He/She has been instructed in and understands the purpose and appropriate method and frequency of administration of this medication.

_____ _____
Physician's Signature **Date**

I agree/assume responsibility that my child can use their medication independently at any school or sponsored activity

_____ _____
Parent's Signature **Date**