COHOES CITY SCHOOL DISTRICT

Medication Permission

Student Name: _____DOB: _____ Grade: _____

To Be Completed by Health Care Provider

Name of Patient: _____ DOB: _____

Diagnosis:_____ Drug Allergies:

Medication: _____ Dose: _____ Route: _____ Freq./Time(s): _____

Medication: _____ Dose: _____ Route: _____ Freq./Time(s):_____

Medication: _____ Dose: _____ Route: _____ Freq./Time(s):_____

Medication: _____Dose: _____ Route: _____ Freq./Time(s): _____

This medication should be given for the entire _____ school year and summer school unless otherwise stated. All medication(s) should be given as close to the prescribed time as possible, however may be given up to one hour before or one hour after the prescribed time. Please advise the school if there is a time-specific concern regarding administration of the medication.

Prescriber please check all that are applicable:

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

____ I have determined this student is consistent and responsible in taking their own medication (**self-directed**) and in addition, give them permission to **self-carry and self-administer** this medication. They will be considered independent in medication delivery and need intervention only during emergencies.

Name and Title of Licensed Prescriber (Please print): _____

Signature of Prescriber: _____ Date: _____ Phone: _____

To Be Completed by Parent

I give permission for the above medication to be administered to my child as ordered by my health care provider. I will furnish the medication in the original pharmacy container, properly labeled with directions and dosage or the original over-the-counter medication container/packaging with my child's name on it.

I give permission for my son/daughter to be **self-directed** regarding his/her medication, if the school nurse determines it is safe and appropriate.

Parent/Guardian Signature: Date: _____

_____ Phone: _____

Parent permission and provider consent are required for students to self-carry medication. Students with this designation are considered independent in taking their medication at school and require no supervision by the nurse. Parents assume responsibility for ensuring that their child carry and take their medication as ordered. Schools may revoke the self-carry privilege if the student proves to be irresponsible or incapable.

Parent/Guardian Signature: Date: _____

_____ Phone: _____