CROTON HARMON SCHOOL DISTRICT

Authorization for Administration of Medication in School and School Activities

Student Name: _____ DOB: _____ Grade: _____

Teacher/HR: _____ School year (valid only for one school year): _____

To Be Completed By Health Care Provider

Diagnosis _____

Important Information / Side Effects _____

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.

MEDICATION NAME	DOSE	FREQUENCY	ROUTE	TIME	✓APPLICABLE BOX BELOW
					☐ Independent ☐ Supervised ☐ Nurse Dependent
					☐ Independent ☐ Supervised ☐ Nurse Dependent
					☐ Independent ☐ Supervised ☐ Nurse Dependent

Prescriber please refer to the categories below for each medication ordered

Independent	I attest that this student has demonstrated to me that he or she 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. Schools may revoke the self-carry/self-administer privilege if the student proves to be irresponsible or incapable.
Supervised	I attest that this student can: • State the name, amount, time and effect of taking/not taking the medication. • Recognize what the medication looks like and refuses to take it if it is the wrong medication or amount. • Swallow, inhale, apply, calculate and take the correct dose of their medication, or request/ direct an adult to assist them, if needed.
Nurse Dependent	Nurse Dependent Students must have their medication administered to them by an appropriate licensed health professional. Please note - * **These medications CANNOT be packed for field trips for supervised administration by a trained staff member.**

_____ _____

Name/Title of Prescriber (please print) **Date**

_____ _____

Prescriber's Signature **Phone**

Prescriber's Stamp

To Be Completed By Parent

I give permission for my child to receive the above medication as prescribed by our provider. I will provide the medication in the original pharmacy container, properly labeled with directions and dosage, or original over-the- counter medication container/package with my child's name on it. I give permission for The Croton Harmon School District Health Office to exchange information with my child physician when care warrants.

Parent/Guardian Signature _____ Date _____ Phone _____

PARENT PERMISSION FOR SUNSCREEN (OPTIONAL) I request that my child be allowed to carry and apply FDA approved sunscreen to her/himself during school or school activities. If sunscreen is needed for medical purposes, an order from a NYS licensed prescriber must be completed.

Parent/Guardian Signature _____ Date _____ Phone _____