Williamsville Central Schools
Encouraging · Nurturing · Challenging

PARENT AND PROVIDER AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

(Includes prescription and over the counter medications)

Student Name: _____ DOB: _____

Grade: _____ Teacher/HR: _____ School: _____

To Be Completed By Health Care Provider

All orders are effective for the entire school year _____including the summer session.

Diagnoses _____

Medication Name	Dose	Route	Time	☑ applicable boxes below
				☐ Bus ☐ Nurse Dependent ☐ Supervised ☐ Independent Use & Carry
				☐ Bus ☐ Nurse Dependent ☐ Supervised ☐ Independent Use & Carry
				☐ Bus ☐ Nurse Dependent ☐ Supervised ☐ Independent Use & Carry
Possible side effects & measures to be taken:				

Provider please use codes below for each medication ordered:

Bus	Medication must be available on bus.
Nurse Dependent Student	I have assessed this student to be nurse-dependent and understand that administration of all prescribed medications must remain the responsibility of the school RN, LPN under the direction of the RN, MD, or parent.
Supervised Student	I have assessed this student to be a supervised student who understands the purpose, name, amount, dose, timing, and effect of taking or not taking the medication, can recognize the medication and refrain from taking it inappropriately and can ingest, inhale, apply or calculate and administer the correct dose of the medication. Unlicensed school staff trained by the school RN may assist the student at the request and direction of the student.
Independent Use and Carry	In some situations, a child with a life-threatening medical condition may have emergency medications that can be used and carried independently (such as an inhaler, epi-pen, insulin, glucose gel). I attest that this student has demonstrated to me the skill and understanding to safely and effectively self-administer the medication(s) listed above, and may carry and use this medication(s) independently at any school/school sponsored activity with no supervision by school staff. **FOR SPORTS AND AFTER-SCHOOL ACTIVITIES, MUST CHECK INDEPENDENT USE & CARRY BOX ABOVE.**

Name and Title of Licensed Provider (Please Print) _____

Provider's Signature _____Date _____ Phone _____

To Be Completed By Parent

I give permission for the above medication(s) to be administered to my child as ordered by my child's health care provider. The medication(s) should be furnished by an adult, in the original pharmacy container, properly labeled with directions and dosage, or original over-the-counter medication container/packaging with my child's name on it. I understand that the school nurse will administer the medication(s) or if my child is deemed a supervised student and no nurse is available, a trained adult will supervise my child taking his/her medication.

Parent/Guardian Signature _____ Date _____ Phone _____

<u>Independent Use & Carry</u> (Additional parental consent is required if independent use & carry box is checked above)

I request that my child be permitted to carry the indicated prescribed life-saving medication(s) on his/her person, locker or PE locker, as I agree that my child can use their medication responsibly, effectively, and independently at school/school sponsored activities with no supervision by school staff. My child has been instructed in and understands the purpose, appropriate method, frequency and use of his/her medication(s). I assume responsibility for ensuring that my child is carrying & taking their medication(s) as ordered. I understand the school may revoke the independent use & carry privilege if my child proves to be irresponsible or incapable.

Parent/Guardian Signature _____ Date _____ Phone _____

Student Signature _____ Date _____

School Nurse: _____ School _____

Phone: _____ Fax: _____ Email _____

(9/2017)