ERIE 1 BOCES
PERMISSION FOR ADMINISTRATION OF MEDICATION

PROVIDER AND PARENT PERMISSIONS
REQUIRED FOR INDEPENDENT MEDICATION USE AND CARRY

DEFINITION OF INDEPENDENT STUDENT: An independent student is one who has demonstrated they can effectively self-administer his or her own medication(s) including inhaled respiratory rescue medications, epinephrine auto-injector, insulin, conduct glucose testing, count carbs and self-correct with an insulin bolus or carbs, operate an insulin pump, carry glucagon and diabetes supplies or other medications which require rapid self-administration and have parent permission to do so without any routine assistance. These tasks are in addition to other self-care activities and documentation that may be required.

Health Care Provider Permission for Independent Use and Carry

Student Name: _____ DOB:_____

Only life-saving medications for life-threatening allergies, respiratory conditions, or diabetes are authorized by this attestation. Other life-saving medications will be reviewed on an individualized basis by the district administration.

The above named student has a diagnosis as checked below. 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) and/or testing kit independently at any school/school sponsored activity with no routine supervision by school staff.

- ❑ Allergy and requires Epinephrine Auto-injector
- ❑ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication
- ❑ Diabetes and requires Insulin/Glucagon/Diabetes Supplies
- ❑ (State Diagnosis) _____which requires rapid administration of (Medication Name)

Signature: _____ Date: _____

Parent/Guardian Permission for Independent Use and Carry

I agree that my child is responsible and understands how to use their medication and/or testing kit effectively, and I give permission for my child to use and carry this medication/testing kit independently at any school/school sponsored activity with no routine supervision by school staff. I will provide medication will be in the original pharmacy labeled or over- the-counter container.

Signature: _____ Date: _____

Please return to School Nurse: FAX_____Email_____

ERIE 1 BOCES
PHYSICIAN'S STATEMENT AND PARENT PERMISSION
FOR ALL OTHER MEDICATION USE AND STORAGE

CHILD'S NAME:
MEDICATION:
DOSAGE:
TIME (s):
DURATION:
POSSIBLE SIDE EFFECTS:
REASON FOR MEDICINE:

BASED ON THE DEFINITIONS BELOW:

□ **SUPERVISED STUDENT**: I assess this child to be sufficiently independent to recognize his medicine, know when and how much he should be taking, and be able to refuse to take the wrong medication from an adult if offered. However, I do not authorize the student to carry and use medication in the school setting and would define this student as needing adult supervision. Therefore, an RN, LPN, or non-medically-licensed staff member with training from the RN may assist the student.

□ **NURSE-DEPENDENT STUDENT:** I assess this child to be a nurse-dependent student and understand that administration of oral, topical, inhalant and injectable medications must remain the responsibility of the school nurse, licensed practical nurse under the direction of a school nurse, physician, or parent.

Physician or other Prescriber Signature: _____
Physician or other Prescriber Name Printed:_____
Date: _____

Parent/Guardian Permission

I give permission for my child to take the above prescribed medication. I agree that my child requires supervision as stated above. I will provide medication in the original pharmacy labeled or over- the-counter container.

Signature: _____
Date: _____

Rev: C. Devore 11/14/16