Lakeland Central School District

Authorization for Medication Administration

Medication of any kind (prescription &/or over the counter) cannot legally be dispensed to any child in school without a health care provider's order and written parental/guardian consent. Medication must be in original pharmacy labeled container with specific orders & brought in by an adult. Medications that can be taken at home before or after school should be arranged in this manner.

Request Form for Administration of Medication to Student in School

Student Name_____Date of Birth_____/_____/_____

I request that my child, _____, grade _____receive the medication prescribed below by our licensed health care provider. The medication is to be furnished by me in the properly labeled original container from the pharmacy. The school nurse may contact the prescriber as needed.

Parent /Guardian Signature _____Date_____

Print Parent/Guardian Name _____ Telephone Number: _____

****************************TO BE COMPLETED BY A HEALTH CARE PROVIDER**

Diagnosis_____

Name of Medication_____Amount of Dosage _____

Time medication is to be administered _____Route _____

Duration of Treatment _____ Expiration Date of Treatment _____

Possible adverse reaction or side effects _____

_____

Physician's Signature _____Date _____/_____/_____

Physician's Stamp and/or Name:_____

Address: _____

_____

Phone: _____ Fax: _____

Provider and Parent Permissions Required for Independent Medication Carry and Use.

(formerly self-administer and/or self-carry) Please Complete the Section below & sign if applicable.

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 and 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 Name)

Signature: _____ Date: _____

Parent/Guardian Permission for Independent Use and Carry

I agree that my child can use their medication effectively and may carry and use this medication independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency.

Signature: _____ Date: _____

This medication order is valid for the school year. Medication must be picked up at the end of the school year or be discarded.

MEDICATION ORDER(S) MAY BE FAXED TO: Fax # 914 _____ Attention: School Nurse