Pawling Central
School District
Administrative Offices
515 Route 22
Pawling, NY 12564

Superintendent of Schools
*William M. Ward, Ed.D.*
845/855-4600

Assistant Superintendent for Instruction
*Kim Fontana*
845/855-2150

Assistant Superintendent for Finance
*Neysa T. Sensenig, Ed.D.*
845/855-4605

Director of Pupil Personnel
*Scott A. Rice*
845/855-4625

Director of Facilities & Operations
*Glen Freyer*
845/855-4610

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Pawling Elementary School
*Debra Kirkhus, Ed.D.*
*Michelle Rivas*, Assistant Principal
7 Haight Street
Pawling, NY 12564
845/855-4630
845/855-4636 (fax)

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Pawling Central Middle School
*Allan Lipsky*, Principal
*Michelle Rivas*, Assistant Principal
80 Wagner Road
Pawling, NY 12564
845/855-4653
845/855-4134 (fax)

Pawling High School
*Helen Callan*, Principal
*John Bellucci*, Director of Athletics
Dean of Students
30 Wagner Road
Pawling, NY 12564
845/855-4620
845/855-2029 (fax)

# PAWLING CENTRAL SCHOOL DISTRICT

## PROVIDER ATTESTATION AND PARENT PERMISSIONS REQUIRED FOR INDEPENDENT MEDICATION CARRY AND USE

**Directions for the Health Care Provider:** This form may be used as an addendum to a medication order which does not contain the required diagnosis and attestation for a student to independently carry and use their medication as required by NYS law. A **provider order** and **parent/guardian permission** is needed in order for a student to carry and use medications that require rapid administration to prevent negative health outcomes. These medications should be identified by checking the appropriate boxes below.

**Student Name:** _____ **DOB:** _____

**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: _____

**Please return to School Nurse:**

| School Nurse: | | School: |
|---|---|---|
| Phone #: | Fax: | Email: |

# PAWLING CENTRAL SCHOOL DISTRICT

## Authorization for Administration of Medication

(Prescription and Non-Prescription)

For Physician (**Please fill in all information requested**):

Name of student _____ DOB _____

Diagnosis _____

Medication prescribed _____

Dosage and route required _____

Time and frequency of medication _____

Duration of medication _____

Adverse reactions/conditions for prn meds to be given _____

_____

** This student can self-administer. Yes _____ No _____

** This student is a "Supervised Student" (able to self- administer with assistance and supervision). Yes _____ No _____

Physician's Name _____ Physician's Signature _____

Date _____ Physician's Telephone # _____

**For Parent/Guardian:**

**I the undersigned, give permission to the school personnel to administer the above named medication during school hours and as prescribed above during field trips and/or school sponsored events. I understand that school personnel are not responsible for any problems arising from taking this medication, its side effects (if any) or for the omission of the medication. I further agree to indemnify and hold harmless the Pawling Central School District and its officers, employees and agents against all claims, suits, demands or any proceeding or actions as a result of any or all acts performed under this authority. I give permission for the physician to be contacted should there be a question regarding this medication or the administration of it.**

My child can self-administer. Yes _____ No _____

My child is a "supervised student" (able to self- administer with assistance and supervision). I understand that assistance and supervision will be provided by an adult chaperone, not a nurse or medical professional.

Yes _____ No _____

Parent/Guardian Signature _____ Date _____

Print Name _____