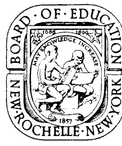

CITY SCHOOL DISTRICT OF NEW ROCHELLE
HEALTH SERVICES DEPARTMENT

MEDICATION ADMINISTRATION FORM

Parent/Provider Authorization for Administration of Medication at School/School Sponsored Events

To Be Completed By Parent/Guardian

Student Name: ____ DOB: _____________________

Grade: ______________ School: ____

I request the school nurse give the medication listed on this plan; trained staff may assist my child to take their own medications; or after the nurse determines eligibility, my child can take their own medications in school. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with school staff caring for my child.

________________________________ ______________________________ _______________
Parent/Guardian Name (Please Print) **Parent/Guardian Signature** **Date**

________________________________ ______________________________
Email **Phone** ❏ **Check if Cell**

To Be Completed By Health Care Provider – Valid for 1 Year

Diagnosis ____ ICD Code ______________

Medication: ____

Dose: ________________________________ Route: ___________________ Time(s)*: ___________

***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.

PERMISSION TO RECEIVE OVER THE COUNTER (OTC) MEDICATION

❏ Acetaminophen (Tylenol for pain, fever)	Dose _______________	Freq.__________	Route___________
❏ Ibuprofen (Advil or Motrin for pain, fever)	Dose _______________	Freq.__________	Route___________
❏ Diphenhydramine (Benadryl for Allergic reaction)	Dose _______________	Freq.__________	Route___________
❏ Antacid (Maalox, Tums for abdominal discomfort)	Dose _______________	Freq.__________	Route___________
❏ Cough Drops/Throat Lozenges (sore throat)	Dose _______________	Freq.__________	Route___________
❏ Antibiotic Ointment (skin lesions)	Dose _______________	Freq.__________	Route___________

ATTESTATION REQUIRED FOR INDEPENDENT CARRY AND USE

NYS Law requires both provider attestation that the student has demonstrated they can effectively self-administer inhaled respiratory rescue medications, epinephrine auto-injector, Insulin, carry glucagon and diabetes supplies, or other medications that require rapid administration, along with parent/guardian permission to allow this in school.

❏ **Check this box and attach the attestation to request this option**.

___________________________________ ________________
Name/Title of Prescriber (Please Print) **Date**

___________________________________ ________________
Prescriber's Signature **Phone**

___________________________________ ________________
Email **Fax**

Stamp

Please return to School Nurse:

School Nurse:		School:
Phone #:	Fax:	Email: