Southern Westchester Boces

Permission to Administer Medications

Student Name: ______________________________ **DOB:** ____________

Grade: _________ **Teacher:** ______________________ **School:** ____________

To Be Completed By Health Care Provider

Diagnoses: ____

Medication Name	Dose	Route	Time	☒ applicable boxes below
				☐ FT ☐Nurse dependent ☐ Supervised ☐ Independent-Self Carry
				☐ FT ☐ Nurse dependent ☐ Supervised ☐ Independent-Self Carry
				☐ FT ☐ Nurse dependent ☐ Supervised ☐ Independent-Self Carry

Prescriber please use codes below for each medication ordered:

Field Trip (FT)	Medication is needed on field trips
Nurse Dependent	Currently, the student does not understand the purpose, name, amount, dose, timing, and/or effect of taking or not taking the medication. Does not understand the condition(s) under which the medication is taken and/or cannot recognize when to refuse the medication.
Supervised Student	I've assessed this student who understands the purpose, name, amount, dose, timing, and effect of taking or not taking the medication. The student is able to recognize the medication and refuse to take it inappropriately; and can ingest, inhale, apply, or calculate and administer the correct dose of the medication. If assistance is needed, they can direct an adult to assist them. The supervised student category is based on cognition and/or emotional development rather than age or grade, as well as the student's ability to consistently and responsibly take their own medications.
Independent/Self Carry	I have assessed this student who is consistent and responsible in self-administering their own medication(s) without assistance (independent classification). In addition, they must be given permission to self-carry and self-administer rescue medication(s) for life-threatening conditions such as respiratory, allergies, and diabetes. They will be considered independent in medication delivery and need intervention only during emergencies.

Stamp

Name and Title of Licensed Prescriber (Please Print) ______________________

Prescriber's Signature ____________________ **Date** __________ **Phone** __________

To Be Completed By Parent

I give permission for the above medication to be administered to my child as ordered by my health care provider. I will furnish the medication 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.

Parent/Guardian Signature ____________________ **Date** __________ **Phone** __________

Independent/Self Carry

Parent permission and provider consent is required for students to self-administer and self-carry medication. Students with this designation are considered independent in taking their medication at school and require no supervision by the nurse. Parents assume responsibility for ensuring that their child is carrying and taking their rescue medication as ordered. School may revoke the self-carry/self-administer privilege if the student proves to be irresponsible or incapable. To request this option please sign below:

Parent/Guardian Signature ____________________ **Date** __________ **Phone** __________

School Nurse: ______________________________ School: __________

Phone: ________________ Fax: ______________ Email: ________________