MAMARONECK UNION FREE SCHOOL DISTRICT

ATTESTATION AND PARENT PERMISSION
REQUIRED FOR INDEPENDENT MEDICATION CARRY AND USE

Directions for the Health Care Provider: This form must be used as an addendum to a medication permission sheet, it is an attestation for a student to independently carry and use his/her medication as required by NYS law. A **provider order** and **parent/guardian permission** are 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 he/she 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
- ☐ Allergy and requires Antihistamine
- ☐ 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 his/her 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: _____

STAMP

PLEASE RETURN TO THE SCHOOL NURSE

4/16

MAMARONECK UNION FREE SCHOOL DISTRICT

Medication Permission Sheet
at School/School - Sponsored Events

To Be Completed By Parent

Student Name: _____ DOB: _____

Grade: _____ Teacher/Counselor_____ School: _____

I request the school nurse give the medication listed on this plan; trained staff may assist my child to take his/her own medications. 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 Signature **Date**

_____ _____
Email **Phone Where We Can Reach You** ☐ **Check if Cell**

Parent signature gives permission to speak to student's physician/ practitioner and school staff as needed

To Be Completed By Health Care Provider-Valid for School Year

Diagnosis: _____

Medication: _____

Dose: _____ **Route:** _____ **Time(s):** _____

Recommendations_____

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.

☐ **Independent Carry and Use Attestation Attached (Required for Independent Carry and Use)**

NYS law requires both provider attestation that the student has demonstrated he/she can effectively self- administer inhaled respiratory rescue medications, epinephrine auto-injector, Insulin, glucagon and diabetes supplies or other medications which require rapid administration along with parent/guardian permission delivery to allow this option in school. Check this box and attach the attestation to this form to request this option.

_____ _____ Stamp
Name/Title of Prescriber (Please Print) **Date**

_____ _____
Prescriber's Signature **Phone**

PLEASE RETURN TO THE SCHOOL NURSE