**Duanesburg Central School District**
165 Chadwick Rd, Delanson, NY 12053
Elementary School: Amber Lounsbury, RN / Brittany Lawrence, LPN
Phone:(518) 895-8350 ext: 229 / Fax: (518) 895-2957
High School: Joanne Newsome, RN
Phone: (518) 895-8350 / Fax: (518) 895-9971

## Permission to Administer Medications

Student Name: _____ DOB: _____

### To Be Completed By Healthcare Provider

| Medication Name | Dose | Route | Time | Check applicable boxes below | Diagnosis |
|---|---|---|---|---|---|
| | | | | ❑ AM_____❑ PM_____ ❑ FT ❑ SSA<br>❑ Self Directed ❑ Self Admin/Self Carry | |
| | | | | ❑ AM_____❑ PM_____ ❑ FT ❑ SSA<br>❑ Self Directed ❑ Self Admin/Self Carry | |
| | | | | ❑ AM_____❑ PM_____ ❑ FT ❑ SSA<br>❑ Self Directed ❑ Self Admin/Self Carry | |

### Prescriber please use codes below for each medication

| | |
|---|---|
| AM | Nurse may administer missed morning dose indicated after verbal or written notification from parent. Please advise parent to send in additional medication |
| Bus | Medication must be available on bus |
| FT | Medication is needed on field trips |
| SSA | Medication is needed for school sponsored extracurricular activities |
| Self- Directed | I assess this student is self-directed regarding their medication. They understand the purpose, name, amount, dose, timing, and effect of taking or not taking medication, can recognize the medication, and refuses to take it inappropriately. Student demonstrated ability to ingest, inhale, apply, or calculate and administer the correct dose of the medication independently at school and school sponsored events. |
| Self-Administer / Self Carry | I have determined this student is consistent and responsible in taking their own medications (self-directed) and in addition, give them permission to self-carry and self-administer this medication. They will be considered independent in medication delivery and need intervention by support staff only during emergencies. |

**Name & 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 healthcare 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_____**

**Administer/Self Carry**

Parent permission and provider consent is required for students to 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 their child is carrying and taking their medication as ordered. Schools 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_____**