



Duanesburg Elementary School
 165 Chadwick Rd.
 Delanson, NY 12053

Nurse's Office
 Amber Lounsbury, RN
 Brittany Lawrence, LPN
 P: (518) 895-8350 ext. 229
 F: (518) 895-2957

Permission to Administer Medications

Student Name: _____ DOB: _____

To Be Completed By Healthcare Provider

Medication Name	Dose	Route	Time	Check applicable boxes below
				<input type="checkbox"/> AM _____ <input type="checkbox"/> PM _____ <input type="checkbox"/> FT <input type="checkbox"/> SSA <input type="checkbox"/> Self Directed <input type="checkbox"/> Self Admin/Self Carry
				<input type="checkbox"/> AM _____ <input type="checkbox"/> PM _____ <input type="checkbox"/> FT <input type="checkbox"/> SSA <input type="checkbox"/> Self Directed <input type="checkbox"/> Self Admin/Self Carry
				<input type="checkbox"/> AM _____ <input type="checkbox"/> PM _____ <input type="checkbox"/> FT <input type="checkbox"/> SSA <input type="checkbox"/> Self Directed <input type="checkbox"/> 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 can ingest, inhale, apply, or calculate and administer the correct dose of the medication independently.
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 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** _____