Ossining Union Free School District

PARENT AND PHYSICIAN’S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION
IN SCHOOL AND SCHOOL ACTIVITIES

In order to protect the health and safety of all students, schools must have a written provider order and written parent/guardian consent in order for a student to be administered a medication, or to permit a student to self-administer their medication at school. A provider order is required for both prescription and non-prescription medications. A provider order is valid for the school year in which it is written, unless the provider changes the order, writes the order for a shorter period of time, or discontinues the order.

The following must be completed:

1. Written authorization from the parent.
2. Written, signed orders from the physician or other healthcare provider
3. The original prescription bottle of medication, or the original over the counter bottle, properly labeled as to its contents.

A. To be completed by the parent or guardian:

I request that my child _____________________________ DOB ____________ receive the medication as prescribed below by our physician.

Signature (Parent or Guardian): __________________________________________

Telephone: Home ____________ Work ____________ Date ______________________

B. To be completed by physician:

Name of Student __________________________________ DOB __________________

Medication ____________________________________________________________

Diagnosis and ICD Code: ________________________________________________

Dosage and Route of Medication: __________________________________________

Frequency/Time to be given: _____________________________________________

If prn, for what symptoms: ______________________________________________

Duration of Treatment:___________________________________________________

*PLEASE COMPLETE IF APPLICABLE*:

Health Care Provider Permission for Independent Use and Carry:

I attest that this student has demonstrated to me that they can self-administer the medication listed below safely and effectively, and may carry and use this medication (with 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:

- Allergy and requires Epinephrine Auto-injector
- 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)

Physician's Signature: ____________________________ Date: ________________

Physician’s Name and Title (print): ____________________________ Phone: __________

Providers Address: ____________________________________________

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Ossining Union Free School District

AUTORIZACIÓN MÉDICA Y DE PADRES PARA LA ADMINISTRACIÓN DE MEDICAMENTOS EN LA ESCUELA Y EN ACTIVIDADES ESCOLARES.

Con el fin de proteger la salud y seguridad de todos los estudiantes, las escuelas deben tener la receta del médico y el consentimiento de los padres por escrito para la administración de medicamentos en la escuela, o para permitir que el estudiante se auto administre el medicamento en la escuela. Una receta médica es necesaria para todos los medicamentos tanto los recetados como para los de venta libre. La orden médica es válida durante el año escolar en que fue escrita, a no ser que el médico cambie la orden, escriba la orden específicamente por un tiempo menor o descontinúe la medicación.

Necesita completar los siguientes documentos:
1. Autorización escrita de los padres o tutores
2. Receta firmada por el médico
3. Recipiente original en el cual la medicación fue dispensada, con la etiqueta original.

A. Para ser completado por el padre o tutor:

Solicito que mi hijo/a _____________________________fecha de nacimiento _____________ reciba la medicina recetada por el médico.

Firma (padre/tutor): _____________________________

Teléfono: casa __________________ trabajo ______________ fecha __________________

B. To be completed by physician:

Name of Student _____________________________ DOB __________________

Medication ________________________________________________

Diagnosis and ICD Code: __________________________________________

Dosage and Route of Medication: __________________________________

Frequency/Time to be given: ______________________________________

If prn, for what symptoms: _________________________________________

Duration of Treatment: ___________________________________________

*PLEASE COMPLETE IF APPLICABLE*:

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  (state diagnosis) __________________________ (medication name)

Physician's Signature: __________________ Date: ______________

Physician’s Name and Title (print): ___________________________ Phone: ______________

Providers Address: ________________________________

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