A black logo with a shield and a helmet

Description automatically generated**Parent and Physician Medication Authorization**

**for School & School Sponsored Events**

**To Be Completed by Parent:**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade: \_\_\_\_\_\_\_\_\_\_\_

* I hereby authorize the school nurse to administer the medication as prescribed below by our physician. In the event the school nurse is unavailable, I give permission for a trained staff member to administer medication to my child.
* I understand that the school nurse or other trained personnel will administer only the prescribed medication described below. If the medicine is changed, a new form for parental consent and a new physician’s order must be completed before the school staff can administer the new medication.
* Over the Counter (OTC) medications must have a healthcare provider order and written parent/guardian consent to be administered at school. If the healthcare provider order is for a name brand OTC medication, but the parent/guardian brings in a different name brand OTC medication or generic brand of the same medication, that is acceptable, and a licensed nurse may administer it.
* Medications that **DO NOT** need a healthcare provider’s order include:

|  |  |  |  |
| --- | --- | --- | --- |
| * Sunscreen | * Cough drops | * Hydrocortisone Cream | * Vaseline |
| * Insect Repellent * Saline Spray | * Mouthwash * Toothpaste | * Antibiotic Ointment (ex: bacitracin, neosporin) | * Aquaphor * Peroxide |
| * Calamine lotion | * Orajel | * Benadryl Cream | * Blistex |

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To Be Completed by Health Care Provider - Valid for 1 School Year:**

|  |  |  |
| --- | --- | --- |
| **Medication** | **Dosage** | **Frequency** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**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.

* **Per MEDICAID requirements - frequency & duration as indicated per individualized education when appropriate.**
* **Independent Carry and Use Attestation (Required for Independent Carry and Use)**: NYS law requires provider attestation that the student has demonstrated they 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 to allow this option in school. Please attach the attestation from your health care provider to this form.

Name/Title of Prescriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please Print)

Prescriber’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please return to:**

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