Riverhead Central School District

MEDICATION SELF- CARRY FORM

PROVIDER ATTESTATION AND PARENT PERMISSION
REQUIRED FOR INDEPENDENT MEDICATION CARRY AND USE

Directions for the Health Care Provider: This form is an addendum to a medication order which does not contain the required diagnosis and attestation for a student to independently carry and use their medication as required by NYS law. A **provider order** and **parent/guardian permission** is 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 they 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
- ☐ 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/Stamp ______________________________ Date: ________________

Parent/Guardian Permission for Independent Use and Carry

I agree that my child can use their 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: ________________

Please return to School Nurse:

School Nurse:		School:
Phone #:		

Riverhead Central School District

REQUEST FOR ADMINISTRATION OF MEDICATION IN SCHOOL

A. TO BE COMPLETED BY THE PARENT/GUARDIAN:

I request that my child __________________________ grade ___________ receive the medication as prescribed below by our licensed health care provider. The medication is to be furnished by me in the **properly labeled original container from the pharmacy. I understand that the school nurse or other designated person in the absence of the school nurse will assist with the administration of the medication.**

Signature (Parent/Guardian)____

Address: ____

Telephone #: Home____________________ Work__________________________

Cell______________________

B. TO BE COMPLETED BY THE LICENSED PRESCRIBER:

I request that my patient, named below, receive the following medication:

Student:__________________________________ Date of Birth:________________

Diagnosis:____

Medication:____

Dosage/Frequency/Route:____

____

Time to be taken during school hours:______________________________________

Duration of treatment:____

Side Effects/Adverse Reactions/Recommendations:______________________________

____

Prescriber's Signature:________________________________ **Date:**_____________

Health Care Provider/Title/**License#/NPI#** **(Please Print or STAMP):**	**PLEASE STAMP IN THIS BOX**
____________________________________	
____________________________________	
____________________________________	
____________________________________	
____________________________________	