ELMWOOD VILLAGE CHARTER SCHOOL
DAYS PARK

Medication at School/School Sponsored Events

To Be Completed By Parent

Student Name: _____ DOB: _____ Grade: _____

I request the school nurse give the medication listed on this plan; or after the nurse determines my child can take their own medications; trained staff may assist my child to take their own medications. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with school staff caring for my child.

_____ _____
Parent/Guardian Signature **Date**

_____ _____
Email **Phone Where We Can Reach You** ☐ **Check if Cell**

To Be Completed By Health Care Provider-Valid for 1 Year

Diagnosis _____

1) Medication _____
Dose _____ Route _____ Time(s) _____
2) Medication _____
Dose _____ Route _____ Time(s) _____
3) Medication _____
Dose _____ Route _____ Time(s) _____

Check the Student's Medication Delivery Status

☐ Nurse Dependent
☐ Supervised Student
☐ Independent Student

An Attestation from Physician is required for Independent Students (specifically for inhalers, Epinephrine auto-injectors and Diabetic management). See attached form

NYS law requires both provider attestation that the student has demonstrated they can effectively self- administer inhaled respiratory rescue medications, epinephrine auto-injector, Insulin, carry glucagon and diabetes supplies or other medications which require rapid administration along with parent/guardian permission delivery to allow this option in school. Check this box and attach the attestation to this form to request this option.

_____ _____
Name/Title of Prescriber (Please Print) **Date**

_____ _____
Prescriber's Signature **Phone**

_____
Email

Stamp

Return to:
Dana Fauth, RN, BSN Ph: 886-4581 Fax: 884-0010

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Physician Attestation

PROVIDER AND PARENT PERMISSION
REQUIRED FOR INDEPENDENT MEDICATION USE

Directions for the Health Care Provider: This form may be used as an addendum to a medication order which does not contain the required diagnosis and attestation for a student to independently use their medication as required by NYS law. A **Provider order** and **parent/guardian permission** is needed in order for a student to 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

I attest that this student has demonstrated to me that they can self-administer the medication(s) listed below safely and effectively, (with a delivery device if needed) independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency.

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 the Diagnosis) (Medication Name)
- ❑ _____ which requires rapid administration of _____
  (State the Diagnosis) (Medication Name)

Signature: _____ Date: _____

Return to:

Dana Fauth, RN, BSN
dfauth@elmwoodvillageschool.org
Ph: 886-4581
Fax: 884-0010