

**Cornwall Central School District
Student Health Services
(845) 534-8009**

CCHS Ext. 5010
FAX: 314-4743

CCMS Ext. 4010
FAX: 534-8309

WAES Ext. 3010
FAX: 534-3474

CES Ext. 2010
FAX: 458-7953

COHES Ext. 1010
FAX: 534-2284

**Provider and Parent Permission to Administer Medication
at School/School Sponsored Events**

To Be Completed By Parent

Student Name: _____ DOB: _____

Grade: _____ Teacher/HR: _____ School: _____

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 _____

Medication _____

Dose _____ Route _____ Time(s) _____

Recommendations _____ ICD Code _____

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.

Independent Carry and Use Attestation Attached (Required for Independent Carry and Use)

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

Stamp

Name/Title of Prescriber (please print)

Date

Prescriber's Signature

Phone

Email