NEWCOMB CENTRAL SCHOOL
Permission to Administer Prescribed Medications

Student Name:_____DOB:_____

To Be Completed and Signed By Health Care Provider

Medication Name and Indication	Dose	Route	Time	Circle one option below
				Supervised Independent Nurse Dependent
				Supervised Independent Nurse Dependent
				Supervised Independent Nurse Dependent

Prescriber please use codes below for each medication ordered:

Supervised	I attest that the student understands the purpose, name, amount, dose, timing, and effect of taking or not taking the medication, can recognize the medication and refuse to take it inappropriately and can ingest, inhale, apply or calculate and administer the correct dose of the medication independently, but requires supervision from a staff member during medication administration.
Independent	I have determined this student is consistent and responsible in taking their own medications (Self-Directed) and in addition, give them permission to self- carry and self-administer this medication. They will be considered independent in medication delivery and need intervention only during emergencies.
Nurse Dependent	Only the nurse may administer the dose indicated after verbal or written notification from the parent and provider.

Name and Title of Licensed Prescriber (Please Print)_____

Prescriber's Signature_____Date _____ Phone _____

Nurse Dependent/Supervised:

I give permission for the above medication to be administered to my child as ordered by my health care provider. I will furnish the medication in the original pharmacy container, properly labeled with directions and dosage, or original over-the-counter medication container/packaging with my child's name on it. Trained staff may assist my child to take their own medications.

Parent/Guardian Signature _____ Date_____ Phone _____

Self-Administer/Self Carry (Independent):

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 to allow this option in school.

Parent/Guardian Signature _____ Date _____ Phone _____