Schalmont CENTRAL SCHOOLS

Student Medication Form

Schalmont Central School District
School Nurse Directory

High School
Sandy Van Etten
svanetten@schalmont.net
355-6110, x3041
Fax: 355-7025
1 Sabre Drive
Schenectady, NY 12306

Middle School
Cheryl Glindmyer
cglindmyer@schalmont.net
355-6255, x2062
Fax: 355-5329
2 Sabre Drive
Schenectady, NY 12306

Jefferson Elementary School
Tara Bush
tbush@schalmont.net
355-1342, x5036
Fax: 357-0296
100 Princetown Road
Schenectady, NY 12306

Schalmont Central School District
District Office
4 Sabre Drive
Schenectady, NY 12306
(518) 355-9200
FAX: (518) 355-9203

Superintendent
of Schools
Dr. Carol A. Pallas
Ext. 4001

Business Office
Joseph Lenz
Business Administrator
Ext. 4002

Special Education Office
Shari Lontrato
Director of Pupil
Personnel Services
Ext. 4018

I hereby give permission for you to administer medication as prescribed by _____ for _____.
(physician) (name of child)

It is understood that no medication can or will be administered by the school nurse until both the parental permission form and the doctor's signed directions are on file in the nurse's office.

☐ Please check box if your child may carry and self-administer an inhaler.
☐ Please check box if your child may carry and self-administer an epipen.

_____
Parent/guardian signature

To: Physician
From: Schalmont Central School
Re: Medication

The following information is required in order for school nurses to administer medication in the school to students during the school day.

Student:_____

Diagnosis: _____

Medication: _____
Dosage: _____
Frequency: _____
Initiation date for medication: _____
Ending date for medication: _____

Medication: _____
Dosage: _____
Frequency: _____
Initiation date for medication: _____
Ending date for medication: _____

☐ Please check box if your child may carry and self-administer an inhaler.
☐ Please check box if your child may carry and self-administer an epipen.

_____ _____
Physician Signature Date

Please return to your child's school nurse.

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PROVIDER AND PARENT PERMISSIONS REQUIRED FOR INDEPENDENT MEDICATION CARRY AND USE

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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 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: _____

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 with no supervision by school staff. 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: _____ 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 with no supervision by school staff.

Signature: _____ Date: _____

Return to your child's school nurse.