HARRISON CENTRAL SCHOOL DISTRICT

Parent/Guardian Request for Student to Self-Carry & Self-Administer Medication

Date: _____

Student Name: _____ Date of Birth: _____

This student has been instructed by a licensed prescriber in the proper use of the following medication procedures:

Diagnosis	Name of the Medication	Dosage Amount	Time to be Administered	Special Instructions

The Parent/Guardian and Physician signatures below indicate a request that this student be permitted to independently carry the medication(s) listed above on his/her person or to keep same in his/her locker or P.E. locker, as we consider him/her responsible. He/she has been instructed by a licensed prescriber about the appropriate method and frequency of use of the medication(s) listed above and understands the purpose of the medication(s).

_____ _____ _____

Parent/Guardian Signature Printed Name Date

_____ _____ _____

Physician Signature Printed Name Date

☐ Check here to confirm that an Emergency Care Plan is attached to this form (required).

By signing below, the student affirms that he/she will comply with the directions for self-administering this medication and will not misuse, or allow others to misuse, the prescribed medication(s).

_____ _____ _____

Student Signature Printed Name Date

This form must be completed and resubmitted by the parent annually.

HARRISON CENTRAL SCHOOL DISTRICT

PARENT AND PRESCRIBER'S AUTHORIZATIONFOR ADMINISTRATION OF MEDICATION IN SCHOOL

A. To be completed by the parent or guardian:

I request that my child_____grade_____ receive medications as prescribed. The medication is to be furnished by me in a pharmacy labeled bottle. I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication. PLEASE NOTE HARRISON CENTRAL SCHOOL DISTRICT POLICY RE: CONTROLLED SUBSTANCE MEDICATION. **AN ADULT SHOULD DELIVER ALL MEDICATION TO THE SCHOOL NURSE. STUDENTS SHOULD NOT BE CARRYING MEDICATION TO SCHOOL. IN THE CASE OF A MEDICATION TERMED A "CONTROLLED SUBSTANCE" (SUCH AS RITALIN, ADDERALL, DEXEDRINE, ET AL) THE MEDICATION MUST BE COUNTED AND SIGNED FOR BY THE NURSE AND THE ADULT DELIVERING IT.**

Signature (Parent or Guardian):_____

Address:_____

Telephone: Home_____Work_____Date_____

B. To be completed by the licensed health care prescriber:
I request that my patient, as listed below, receive the following medication:

Name of Student:_____DOB:_____

Diagnosis:_____

Name of Medication:_____

Prescribed Dosage and Frequency:_____

Time to be taken during school hours:_____

Name of Licensed Prescriber and Title:_____
(Please Print)

Prescriber Signature:_____Date:_____

Address:_____Phone_____

HARRISON CENTRAL SCHOOL DISTRICT

Parent/Guardian Designation of Authorized Adult to Administer Medication on a Field Trip

To be completed by parent/guardian. ***This form must be completed and resubmitted by the parent before each field trip.***

I authorize _____ , my
(name of designee)

friend, family member, household member or other relationship appropriate in accordance with Education Law §6908, to administer the following medication(s) according to the following directions:

Name of the Medication	Dosage Amount	Time to be Administered	Special Instructions

The medications listed above are to be administered to my child _____
(student name)

at the following school-sponsored event:

_____.
(name and date of event)

I acknowledge that the Harrison Central School District will not be liable for any problems that may arise as a result of the administration of such medication by the authorized designee.

_____	_____	_____
Parent/Guardian Signature	Printed Name	Date
_____	_____	_____
Authorized Adult Signature	Printed Name	Date
_____		_____
School Nurse		Date

The parent/guardian is responsible for providing the medication(s) directly to the adult who is authorized to administer the medication in the parent/guardian's absence.