ROCKVILLE CENTRE UNION FREE SCHOOL DISTRICT

PARENT/PERSON IN PARENTAL RELATION AND PRESCRIBER AUTHORIZATION FOR ADMINISTARTION OF MEDICATION RELEASE FORM

A. To be completed by the parent or person in parental relation:

I request that my child, ___________________________, date of birth, ______________, receive the medication prescribed below by his/her physician or other NYS licensed healthcare prescriber. The medication is to be furnished by me in the properly labeled original pharmacy container or over-the-counter container that is labeled with specific name of the medication and dosing orders.

Signature of Parent or Person in Parental Relation: ___________________________________

Date: _________________

Address: ____

____

Home Telephone: ___________________ Work Telephone: ____________________________

B. To be completed by the physician or other NYS licensed healthcare provider:

I request that my patient, as listed below, receive the following medication.

Student's Name: ________________________________ Date of Birth: __________________

Diagnosis: ____

Medication	Dosage	Frequency/Time to be taken	Route of Administration

Duration of treatment: ____

Possible side effects and adverse reactions (if any): ___________________________________

____

Other recommendations: ____

Please continue on reverse
Signature required

PLEASE CHECK ONE:

[ ] NURSE DEPENDENT STUDENT: I deem this child to be a nurse-dependent student and understand that administration of oral, topical, inhalant and injectable medications must remain the responsibility of the school nurse, licensed practical nurse under the direction of a school nurse, physician, or parent.

[ ] SUPERVISED STUDENT: I deem this child to be a supervised student who can recognize his or her own medication, knows when and how much of the medicine he or she should be taking and is able to refuse the wrong medication from an adult if offered. However, I would define this student as requiring adult supervision and therefore, an RN, LPN, or non-medically-licensed staff member with training from the RN may assist the student in administering his or her medication.

[ ] INDEPENDENT STUDENT: I attest that this child is an independent student who has demonstrated the skill and understanding to carry and self-administer his or her own prescribed medication (s) effectively without assistance from an adult limited to those rescue medications prescribed for respiratory conditions, life-threatening allergies, or diabetes, or certain other health condition(s), as determined on a case by case basis, which warrant rapid administration or prescribed medication(s).

Name of NYS Licensed Provider and Title (please print):

____

Address: ____

Office Telephone #: ________________________ Fax #: ______________________________

Provider's Signature: ____

Date: ________________________ Provider's Stamp: __________________________________

TO BE COMPLETED IF CHILD IS DEEMED AN INDEPENDENT STUDENT:

Parent or Person in Parental Relation Permission for Independent Students

I agree that my child is responsible and understands how to use his or her medication and/or testing kit effectively and I give permission for my child to use and carry this medication/testing kit independently at school/school-sponsored activities with no routine supervision by school staff.

Name of Parent/Person in Parental Relation (please print): ____________________________

Parent/Person in Parental Relation Signature: ____

Date: ________________________

C. **TO BE COMPLETED BY SCHOOL NURSE:**

I have interviewed the student and he/she has been instructed in and understands the purpose of taking the medication prescribed by his/her prescriber.

School Nurse's Signature: ________________________________ Date: ____________________