Pittsford Central School District

Permission to Administer Medication in School and During School Sponsored After School and Weekend Activities/Sports

School Year _____
Grade _____
Teacher _____

TO BE COMPLETED BY THE STUDENT'S PHYSICIAN

Student's Name _____ Date of Birth _____

Medication Dose Route Time(s) ___

Purpose _____ _____ _____

Side Effects _____

All medications should be given as close to the prescribed time as possible, however may be given up to one hour before and no later than one hour after the prescribed time. Please advise the school if there is a time-specific concern regarding administration of the medication.

Physician please check if applicable:

- ☐ If morning dose is not given at home, nurse may administer **morning dose of** _____ after verbal or written notification from parent.
- ☐ Medication **should** be taken on field trips.
- ☐ Medication **should** be given during school sponsored after school and/or weekend activities/sports

Physician's Signature _____ **Date** _____

Physician's Name (Please Print) _____ **Phone** _____

I give permission for the above medication to be administered to my child as ordered by my health care provider and for the school nurse to share information with physician regarding this medication.

Parent's Signature _____ **Date**

Permission for Students to Carry Medication

A student may self-carry if:

- The student is in grades 6-12. An exception to this rule is when the medication is a metered dose inhaler for asthma, an Epi-Pen, diabetic medication or Lactaid in which case younger students may be permitted to carry and self-administer.
- The medication is **not:** a controlled substance, psychotropic, for ADHD, or contains dextromethorphan (DMX) or stimulant decongestants.
- An assessment by the school nurse confirms that the student is self-directed to carry and self-administer her/his medication properly.
- Parent assumes responsibility for insuring that his/her child is carrying and taking the medication as ordered.

I give permission for this student to self-carry and self-administer the above medication as I consider her/him responsible. He/She has been instructed in and understands the purpose and appropriate method and frequency of administration of this medication.

_____ _____

Physician's Signature* **Date**

I assume responsibility for ensuring that my child is carrying and taking his/her medication as ordered.

_____ _____

Parent's Signature **Date**

* A non-parent licensed prescriber is required for all prescription medication