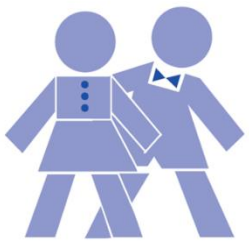

GLENS FALLS PEDIATRICS CONSULTANTS PC
PEDIATRIC ASSOCIATES OF SARATOGA

PERMISSION TO ADMINISTER MEDICATION IN SCHOOL

I request that my patient receive the following medication, administered by the School Nurse or authorized school personnel during school hours:

Name of the Student: _____ Date of Birth _____

Diagnosis: _____

Name of medication, dosage, time and route of administration:

_____

Duration of Treatment: _____ School Year

_____ To be discontinued on: _____

Potential side effects: _____

_____ _____ _____

Physician (prescriber's) signature: Print Prescriber's name/Title Date

NPI# _____ License # _____

PLEASE CHECK ONE:

□ I deem this child to be self directed and may self carry and self administer medication. I attest that this student has demonstrated to me the they can self-administer the medication(s) listed above safely and effectively and may carry and use this medication (with delivery device if needed), independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency. This order applies to the medications listed above.

□ I deem this child to be self directed and understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication, including field trips.

□ I deem this child to be non self-directed 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.

_____ _____ _____

Parent/guardian signature Relationship to child Date