Heatly School
GREEN ISLAND UFSD

171 Hudson Avenue Green Island, NY 12183 P: (518) 273-1422
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Daniel Kalbfliesh *Superintendent*
Stephanie Bouchey *Principal*
Angela E. Legault *District Clerk*
Christopher Karwiel *Business Manager*
Kimberly Watkins *District Treasurer*

Medication Permission for Provider and Parent/Guardian for School/School Sponsored Events

To Be Completed by Parent or Guardian

Student Name: _____ Grade_____DOB: _____

Teacher/HR: _____ School: _____

I request the school nurse give the medication listed on this plan, or after the nurse determines my child can take their own medications; trained staff may assist my child to take their own medications. I will provide the medication in the original pharmacy or over-the-counter container.

_____ _____
Parent/Guardian Signature **Date**

_____ _____
Email **Phone Where We Can Reach You** ☐ **Check if Cell**

This information will be shared with appropriate school staff as needed to protect your child's health and safety and support their academic progress.

To Be Completed by Health Care Provider-Valid for 1 Year

Diagnosis _____

Medication Name_____

Dose _____ Route _____ Administration Time(s) _____

Recommendations_____ ICD Code _____

Note: Medication will be given as close to the prescribed time as possible, but may be given up to one hour before or after the prescribed time. Please advise if there is a time-specific concern regarding administration.

☐ **Per MEDICAID requirements, frequency & duration as indicated "per" IEP when appropriate.**

☐ **Independent Carry and Use Attestation Attached (Required for Independent Carry and Use As Described Below)**

NYS law requires both provider attestation that the student has demonstrated they can effectively self- administer inhaled respiratory rescue medications, epinephrine auto-injector, Insulin, carry glucagon and diabetes supplies or other medications which require rapid administration along with parent/guardian permission delivery to allow this option in school. Check this box and attach the attestation to this form to request this option.

_____ _____
Prescriber Name/Title of (Please Print) **Date**

_____ _____
Prescriber's Signature **Phone**

_____
Prescriber's Email

Stamp

Return to:

School Nurse: Rebecca Bushey, RN		School: Green Island Union Free School District
Phone #: 518-273-1422 opt 1	Fax: 518-270-0818	Email: RBushey@greenisland.org