Western Suffolk BOCES Marine Studies Enrichment Program

Provider and Parent Permission to Administer Medication

**To be completed ONLY if student is required to take/carry medications during this program*

To Be Completed By Parent

Student Name: _____ DOB: _____

I request the program staff give the medication listed on this plan; staff may assist my child to take their own medications. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with staff caring for my child.

_____ _____

Parent/Guardian Signature **Date**

_____ _____

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

To Be Completed By Health Care Provider

Diagnosis #1 _____

Medication _____

Dose _____ Route _____ Time(s) _____

Recommendations_____ ICD Code _____

Diagnosis #2 _____

Medication _____

Dose _____ Route _____ Time(s) _____

Recommendations_____ ICD Code _____

(Attach additional sheets as necessary)

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.

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

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 during program. Check this box and attach the attestation to this form to request this option.

_____ _____

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

_____ _____

Prescriber's Signature **Phone**

_____

Email

Stamp

PROVIDER ATTESTATION AND PARENT PERMISSIONS

FOR INDEPENDENT MEDICATION CARRY AND USE

Directions for the Health Care Provider: This form may be used as an addendum to a medication order which does not contain the required diagnosis and attestation for a participant to independently carry and use their medication as required by NYS law. A **provider order** and **parent/guardian permission** are needed in order for a participant to carry and use medications that require rapid administration to prevent negative health outcomes. These medications should be identified by checking the appropriate boxes below.

Student Name: _____ DOB: _____

Health Care Provider Permission for Independent Use and Carry

I attest that this student has demonstrated to me that he or she can self-administer the medication(s) listed below safely and effectively, and may carry and use this medication (with a delivery device if needed) independently during the Marine Studies Enrichment Program. Staff intervention and support is needed only during an emergency. This order applies to the medications checked below:

This student is diagnosed with:

- ❑ Allergy and requires Epinephrine Auto-injector
- ❑ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication
- ❑ Diabetes and requires Insulin/Glucagon/Diabetes Supplies
- ❑ _____which requires rapid administration of _____
  (State Diagnosis) (Medication Name)

Signature: _____ Date: _____

Parent/Guardian Permission for Independent Use and Carry

I agree that my child can use their medication effectively and may carry and use this medication independently during the Marine Studies Enrichment Program. Staff intervention and support is needed only during an emergency.

Signature: _____ Date: _____