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 Con	npleted By Pa	rent			
Student Name:			DOB:			
I request the program staff gives medications. I will provide the will be shared with staff carin	e medication in the o	•				
Parent/Guar	dian Signature			Date		
Ema	ail	Phon	e 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 additio	nal sheets as ne	cessary)			
Note: Medication will be given a or after the prescribed time. Ple	•	•		hour before		
□ Independent Carry and U NYS law requires both provider a inhaled respiratory rescue medic other medications which require option during program. Check th	attestation that the stu cations, epinephrine au e rapid administration a	dent has demons ito-injector, Insul along with parent,	in, carry glucagon and diabeter /guardian permission delivery form to request this option.	f- administer s supplies or		
Name/Title of Prescriber	(Please Print)	Date	Stamp			
Prescriber's Signature	<u></u> -	Phone				
	Email					

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 I	Name:
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_____ DOB: ____

Health Care Provider Permission	for Independent Use and Carry
I attest that this student has dem	onstrated 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) indep	pendently during the Marine Studies Enrichment Program.
Staff intervention and support is medications checked below:	needed only during an emergency. This order applies to the
This student is diagnosed with:	
Allergy and requires Epinephr	rine Auto-injector
Asthma or respiratory conditi	on and requires Inhaled Respiratory Rescue Medication
Diabetes and requires Insulin,	/Glucagon/Diabetes Supplies
۷۷	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: _____

Date:	