

**Gardner Dickinson School**

**Health Office**

Phone 518-283-4600 x3 fax 518-283-0362

**Permission to Administer Multiple Medications**

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**To Be Completed By Health Care Provider**

Diagnoses \_\_\_\_\_

Medication Name	Dose	Route	Time	<input checked="" type="checkbox"/> applicable boxes below			
				<input type="checkbox"/> AM _____	<input type="checkbox"/> Bus	<input type="checkbox"/> FT	<input type="checkbox"/> SSA
				<input type="checkbox"/> Self-Directed	<input type="checkbox"/> Self Admin-Self Carry		
				<input type="checkbox"/> AM _____	<input type="checkbox"/> Bus	<input type="checkbox"/> FT	<input type="checkbox"/> SSA
				<input type="checkbox"/> Self-Directed	<input type="checkbox"/> Self Admin-Self Carry		
				<input type="checkbox"/> AM _____	<input type="checkbox"/> Bus	<input type="checkbox"/> FT	<input type="checkbox"/> SSA
				<input type="checkbox"/> Self-Directed	<input type="checkbox"/> Self Admin-Self Carry		

**Prescriber please use codes below for each medication ordered:**

<b>AM</b>	Nurse may administer missed morning dose indicated after verbal or written notification from parent. Please advise parent to send in additional medication
<b>Bus</b>	Medication must be available on bus
<b>FT</b>	Medication is needed on field trips
<b>SSA</b>	Medication is needed school sponsored extra-curricular activities
<b>Self-Directed</b>	I assess this student is self-directed regarding their medication. They understand the purpose, name, amount, dose, timing, and effect of taking or not taking the medication, can recognize the medication and refuse to take it inappropriately and can ingest, inhale, apply or calculate and administer the correct dose of the medication independently.
<b>Self-Administer/ Self-Carry</b>	I have determined this student is consistent and responsible in taking their own medications (Self-Directed) and in addition, give them permission to self- carry and self-administer this medication. They will be considered independent in medication delivery and need intervention only during emergencies.

**Name and Title of Licensed Prescriber (Please Print)** \_\_\_\_\_

**Prescriber's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_ **Phone** \_\_\_\_\_

**To Be Completed By Parent**

I give permission for the above medication to be administered to my child as ordered by my health care provider. I will furnish the medication in the original pharmacy container, properly labeled with directions and dosage, or original over-the-counter medication container/packaging with my child's name on it.

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Self-Administer/Self Carry**

Parent permission and provider consent is required for students to self-administer and self-carry medication. Students with this designation are considered independent in taking their medication at school and require no supervision by the nurse. Parents assume responsibility for ensuring that their child is carrying and taking their medication as ordered. Schools may revoke the self-carry/ self-administer privilege if the student proves to be irresponsible or incapable. To request this option please sign below:

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_ **Phone** \_\_\_\_\_