Canandaigua City School District

School District Health Office Contacts

Middle Academy 585-396-3860 / **FAX** 585-396-3874
585-396-3820 / **FAX** 585-396-3957

143 North Pearl Street, Canandaigua, New York 14424 www.canandaiguaschools.org

Provider and Parent/Guardian Permission to Administer Medication at School/School Sponsored Events (Grades 6-12)

To be completed by the Parent/Guardian

Student Name: _____ DOB: _____

Grade: _____ Teacher/HR: _____ School: _____

I request the school nurse give medication listed on this plan; or after the nurse determines my child is self-directed, trained staff may assist my child (in the absence of the nurse) to take their own medication. I will provide the medication in the original pharmacy or over the counter container, with a proper expiration date. Medication and refills must be brought to school by an adult.
This plan will be shared with school staff caring for my child.

_____ _____
Parent/Guardian Signature Date

_____ _____
Email Phone where we can reach you

To Be Completed by Health Care Provider-*Valid for the Current School Year*

Diagnosis _____ ICD 10 Code _____

MEDICATION	DOSAGE	FREQUENCY/TIME/DURATION TO BE TAKEN	ROUTE OF ADMINISTRATION

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.

❑ I attest that this student has demonstrated to me that they can self-administer the medication(s) ❑ Inhaler, ❑ Epi Pen, ❑ insulin/glucagon/diabetic supplies safely and effectively, and may carry and use this medication independently at school/for school sponsored events.

_____ _____
Name/Title of Prescriber (please print) Date

_____ _____
Prescriber's Signature Phone

License # _____ NPI #_____

Prescriber's address

Dismissal on half days:

❑ Yes, please give my child his/her medication on half days.
❑ No, please do not give my child his/her medication on half days.