Permission to Administer Medications (Prescription and Over-the-Counter) (Page 1/2)

Child Name: _____ DOB: _____ Weight: _____ Date_____

To Be Completed by Healthcare Provider

Have this form completed if your child needs or may need prescription and/or over-the-counter (OTC) medication during program hours. **NO medication will be given unless this form is signed by a medical provider AND parent.** The OTC medications below can be provided by LREI if this form is executed in full.

Over-the Counter Medication (OTC)

Medication	Dose and	Route & Frequency	Indication	Approval Indication
Ibuprofen (Advil/Motrin)	_____mg _____ml (100mg/5ml)	PO Every 6-8 hours	Pain or fever above 100.4	Yes No
Acetaminophen (Tylenol)	_____mg _____ml (160mg/5ml)	PO Every 4-6 hours	Pain or fever above 100.4	Yes No
Calcium Carbonate (Tums)	_____mg (500mg tabs)	PO every 6 hours	Indigestion, heart burn or stomach irritation	Yes No
Diphenhydramine (Benadryl)	_____ mg _____ml (12.5mg/5ml)	PO Every 6 hours	Hives, itching or other allergic reaction. If anaphylaxis is suspected, Epinephrine will be administered first.	Yes No
Hydrocortisone 1% ointment	1 application	Topical Up to three times daily	Skin irritation, itching, insect bites	Yes No
Bacitracin Ointment	1 application	Topical As needed	Abrasions and minor wounds	Yes No
Cough Drops	1 drop	PO Up to three times daily	Cough or sore throat in child 10 years and older	Yes No

Prescription Medications

Complete for all prescription medications the child may need during program hours.

Medication	Dose	Route	Time	Skill Level (check one)	I attest child demonstrated ability to self-administer the prescribed medication effectively for school/fieldtrips (Independent children only)
				○ **Nurse Dependent** ○ **Supervised** ○ **Independent**	Practitioner Initials (Independent only)
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				○ **Nurse Dependent** ○ **Supervised** ○ **Independent**	Practitioner Initials (Independent only)
				○ **Nurse Dependent** ○ **Supervised** ○ **Independent**	Practitioner Initials (Independent only)

Nurse Dependent: Nurse must administer **Supervised:** Self-administration under adult supervision
Independent: self-carry/self-administer **(NO CONTROLLED SUBSTANCES)**

Permission to Administer Medications (Prescription and Over-the-Counter) Continued (2/2)

Child Name: _____ DOB: _____

Health Care Practitioner

LAST NAME _____FIRST NAME_____Circle: MD, DO, NP, PA

Address_____ Phone_____

NYS License Number **(Required)** _____NPI _____

Signature _____Date_____

Parent(s)/Guardian(s)

I give permission for the above medication(s) to be administered to my child as ordered by my healthcare provider. I will furnish the medication in the original packaging/container, properly labeled with directions and dosage, with my child's name on it. I will update the program if there is a medication change.

I acknowledge that my child must comply with all School rules regarding medication administration and self-administration. I, on behalf of my children, spouse, heirs, agents, executors, administrators, and assigns, release and forever discharge the School, its agents, trustees, officers and employees for any and all demands, claims, damages, actions, and causes of action pertaining to or arising out of my child taking or being provided with medication while traveling on trips or during any activity and program. I understand that as a result of my executing this release of claims, I and the releasing parties set forth above will be forever barred from suing the School as a result of the School administering medication to my child or my child self-administering medication. I agree to hold harmless the School and the released parties set forth above against any claims arising out of the administration of medication by the School or self-administration by my child.

Parent/Guardian Name _____ Signature _____ Date_____

Parent/Guardian Name _____ Signature _____ Date_____

Self-Administration Release (Independent only)

Parent/guardian permission and provider consent is required for students to self-administer and/or self-carry medication. No controlled substances can be self-carried or administered. Students with this designation are considered independent in taking their medication and require no nurse supervision or monitoring. Parents assume responsibility for ensuring that their child is carrying and taking their medication as ordered.

I represent that the student is capable and competent to understand a personal care procedure, can correctly administer the medication to him/herself each time that it is required, has the ability to make choices about the activity, understands the impact of those choices, and assumes responsibility for the results of those choices. Further, the student has been instructed in the procedure for self-administration and can assume the responsibility for self-administering his/her medication properly. The School may revoke the self-carry/self-administer privilege if the student proves to be irresponsible or incapable.

Parent/Guardian Name _____ Signature _____ Date_____

Parent/Guardian Name _____ Signature _____ Date_____