



SOUTHERN WESTCHESTER BOCES

BOARD OF COOPERATIVE EDUCATIONAL SERVICES

Permission to Administer Medications

Student Name: _____ DOB: _____

Grade: _____ Teacher: _____ School: _____

To Be Completed By Health Care Provider

Diagnoses _____

Medication Name	Dose	Route	Time	☒ applicable boxes below
				☐ FT ☐ Nurse Dependent ☐ Supervised ☐ Self Admin-Self Carry
				☐ FT ☐ Nurse Dependent ☐ Supervised ☐ Self Admin-Self Carry
				☐ FT ☐ Nurse Dependent ☐ Supervised ☐ Self Admin-Self Carry

Prescriber please use codes below for each medication ordered:

Field Trip (FT)	Medication is needed on field trips
Nurse Dependent	Currently, the student does not understand the purpose, name, amount, dose, timing and/or effect of taking or taking the medication. Does not understand the condition(s) under which medication is taken and/or cannot recognize when to refuse the medication.
Supervised Student	I have assessed this student who understands the purpose, name, amount, dose, timing and/or effects of taking or not taking this medication. The student is able to recognize the medication and refuse to take it inappropriately and can ingest, inhale, apply, or calculate and administer the correct dose of medication. If assistance is needed, they can direct an adult to assist them. The supervised student category is based on cognition and/or emotional development rather than age or grade, as well as the student's ability to consistently and responsibly take their own medication.
Self-Administer/ Self-Carry	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) _____ Stamp

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 rescue 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 _____

School Nurse: _____ School: _____

Phone: _____ Fax: _____ Email: _____