DISTRITO ESCOLAR DE LA CIUDAD DE WHITE PLAINS
Permiso para Administrar Una Medicina

Nombre del Estudiante: _____ DOB: _____

Grado: _____ Profesor/HR: _____ Escuela: _____

To Be Completed By Health Care Provider

Diagnosis _____

Medication _____ Dose _____ Route _____ Time(s) _____

Recommendations_____ ICD Code _____

All medication should be given as close to the prescribed time as possible, however may be given up to one hour before and no later than one hour after the prescribed time. Please advise the school if there is a time-specific concern regarding administration of the medication.

Prescriber please check all that are applicable:

❑ If morning dose is not given at home, nurse may administer morning dose of _____ after verbal or written notification from parent. Please advise parent to send in additional medication

❑ Medication is required: ❑ On field trips ❑ On school-sponsored after school sports

❑ I assess this student to be **self-directed*** regarding this 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.

❑ 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 _____

Para ser Completado por el Padre

Yo autorizo que la medicina indicada le sea administrada a mi niño/a conforme está ordenado por su doctor. Yo proporcionaré la medicina en su frasco original de la farmacia, propiamente etiquetado con las indicaciones y dosaje, o medicina sin receta médica en su frasco original/paquete con el nombre de su niño.

Nota: Los estudiantes sólo pueden auto-transportar los Auto Inyectores de Epinephrine o inhaladores para el asma.

Firma del Padre/Guardián _____ Fecha _____ Teléfono _____

Permiso Adicional para Auto-Medicarse/Auto-Transportar (Requiere el Consentimiento del Doctor de Arriba)

Se requiere el permiso del padre y doctor para que los estudiantes se auto-mediquen y auto-transporten su medicina. **Los estudiantes con esta designación son considerados independientes para transportar sus medicinas a la escuela y no requiere supervisión de la enfermera.** Los padres asumen la responsabilidad de garantizar el que sus niños transporten sus medicinas como está ordenado. Las escuelas pueden revocar este privilegio de auto-transporte o auto-medicarse si el estudiante demuestra ser irresponsable o incapaz. Para solicitar esta opción, firme abajo:

School Nurse: _____ School _____

Phone: _____ Fax: _____ Email _____