



Duanesburg Central School District

165 Chadwick Rd, Delanson, NY 12053

Elementary School: Janell Sindoni, RN

Phone:(518) 895-8350 ext: 229 / Fax: (518) 895-2090 / jsindoni@duanesburg.org

High School: Stephanie Yauchler, RN

Phone: (518) 895-3000 ext: 240 / Fax: (518) 895-8560 / syauchler@duanesburg.org

**PROVIDER ATTESTATION AND PARENT PERMISSIONS
FOR INDEPENDENT MEDICATION CARRY AND USE**

Directions for the Health Care Provider: This form may be used as an addendum to a medication order which does not contain the required diagnosis and attestation for a student to independently carry and use their medication as required by NYS law. A **provider order** and **parent/guardian permission** are needed in order for a student to carry and use medications that require rapid administration to prevent negative health outcomes. These medications should be identified by checking the appropriate boxes below.

Student Name: _____ **DOB:** _____

Health Care Provider Permission for Independent Use and Carry

I attest that this student has demonstrated to me that he or she can self-administer the medication(s) listed below safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency. This order applies to the medications checked below:

This student is diagnosed with:

- Allergy and requires Epinephrine Auto-injector
- Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication
- Diabetes and requires Insulin/Glucagon/Diabetes Supplies
- _____ which requires rapid administration of _____
(State Diagnosis) (Medication Name)

Signature: _____ **Date:** _____

Parent/Guardian Permission for Independent Use and Carry

I agree that my child can use their medication effectively and may carry and use this medication independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency.

Signature: _____ **Date:** _____

Please return to School Nurse: