Rome Free Academy

95 Dart Circle
Rome, New York 13441

Nurse's office Telephone (315) 334-7222
Fax (315) 334- 7247

Permission to Administer Medication

School Health Office

I request that the RFA Nurse administer the medication prescribed by my Health Care Provider, ___________________, for my son/daughter, ____________________, during school hours.

____________________ ________
Parent/ Guardian signature Date

All medication must be provided by the parent or guardian in original container.

Physician Statement

Student's Name: ______________________________ DOB: ________________

Description of Medication or Service: ____

Dosage: ________ Frequency of Dose: _____________ Beginning: ________ to ___________

Diagnosis and/or Reason/Need for Service: ____

ICD-9 Code______________________

____________________ ________ ____________________
Health Care Provided Signature Date Address

____________________ ____________________
Print Name

____________________ ____________________ ____________________
License Number NPI Number (if applicable) Phone/ Fax

Note: All Documentation in the above "Physician Statement" is required for billing Medicaid effective 9/1/10.

Permission To Self Administer Asthma Medication or Epipen

The student listed above has demonstrated the ability to use his/her asthma medication or Epi-pen correctly and should be allowed to carry it on his/her person and self administer when needed. He/she has been given instructions and verbalizes the purpose and appropriate method and frequency of use.

____________________ ________ ____________________ ________
Health Care Provided Signature Date Parent/Guardian Signature Date