Syosset Central School District
Syosset, New York 11791

AUTHORIZATION 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)

Physician's Signature: ________________________ Date: ________________

Physician's Stamp:

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:

School Nurse: Maureen Henshaw RN		School: HB Thompson Middle School
Phone #: (516)364-5765	Fax: (516)837-8988	Email: mhenshaw@syossetschools.org

(OVER)

SYOSSET CENTRAL SCHOOL DISTRICT
Syosset, NY

REQUEST FOR ADMINSTRATION OF MEDICATION DURING SCHOOL DAY

Student's Name________________________________ Age______ Grade________

Home Address________________________________ Phone #____________

School________________________________ Student ID#____________

Dear Parent:

In order for any medication, prescription or over-the-counter, to be taken in school, state law requires a written request from a physician indicating the frequency and the dosage of such medication.

The nurse must also have on file a written request from the parent to administer the medication. A new form must be filled out for each change of medication and renewed each school year.

PART I — TO BE COMPLETED BY PARENT OR GUARDIAN

I request that the school nurse administer the medication as requested by my physician to my child

________________________________.

I will supply the school nurse with the medication in a container, professionally labeled by the pharmacist; or for an over-the-counter medication; it will be in its original container labeled with the student's name and grade.

____________________ Signature

____________________ Relationship

____________________ Date

____________________ Work Telephone

PART II — TO BE COMPLETED AND SIGNED BY PHYSICIAN

Student's Name____________________________ Date____________

A. Name of Medication____________________________

B. Dosage (1) amount to be given____________________________

(2) time to be given____________________________

C. Side Effects (1) to report____________________________

(2) to expect____________________________

____________________ Signature of Physician

____________________ Stamp of Physician

____________________ Telephone Number