MOUNT SINAI UNION FREE SCHOOL DISTRICT
P.O. BOX 397, NORTH COUNTRY ROAD
MOUNT SINAI, NEW YORK 11766

PARENT/PHYSICIAN AUTHORIZATION FOR ADMINISTRATION OF MEDICATION FOR IN-SCHOOL USE AND SCHOOL TRIPS

A. To be completed by Parent/Guardian: **Grade Level** ______________

I request that my child, ______________________________, receive the medication as prescribed by my physician.

Name of Parent/Guardian *(Please print.)*: ______________________________

Signature of Parent/Guardian: ______________________________ Date: ______________

Home Phone: ______________________________ Cell Phone: ______________________

B. To be completed by Physician:

Allergies: ______________________________

I request that my patient, as listed below, receive the following medication (prescription and over-the-counter):

Name of Student (*Please print.*): ______________________________

1. Diagnosis: ______________________ Medication: ______________________

   Dosage, Frequency, Route, Time & Side Effects:

   ____

   ____

2. Diagnosis: ______________________ Medication: ______________________

   Dosage, Frequency, Route, Time & Side Effects:

   ____

   ____

Name of Physician *(Please print.)*: ______________________________

Address: ______________________________

Signature/Stamp: ______________________________ Date: ______________

This form must be completed for students to carry and administer their own medication (prescription and over-the-counter) in school and on school trips along with the Self-Medication Release Form (A or B as applicable).

Updated 8/2017

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SELF-MEDICATION RELEASE
FORM A

Grade Level: ________________

Student's Name *(Please print.)*: ____ has been instructed in the proper use of the following medication procedures:

Name of medication: ____

Procedures: ____

____

____

____

We request that the above named student be permitted to carry the medication on his/her person. We consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use.

____ ________________________
Signature of Physician *Date*

____ ________________________
Signature of Parent/Guardian *Date*

NOTE:
This form must be completed in addition to the ***Parent/Physician Authorization for Administration of Medication for In-School Use and on School Trips*** for those students who request permission to carry and administer their own medication (prescription and over-the-counter) on school trips.

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SELF-MEDICATION RELEASE

FORM B

PROVIDER AND PARENT PERMISSIONS REQUIRED 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** is 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's Name: ______________________________ **DOB:** ____________________

Grade Level: ________________

Health Care Provider Permission for Independent Use and Carry

I attest that this student has demonstrated to me that they 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 with no supervision by school staff. 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 with no supervision by school staff.

Signature: ______________________________ Date: ____________________

Please return to the School Nurse:

School Nurse:		School:
Phone #:	Fax:	Email:

NOTE: This form must be completed in addition to the *Parent/Physician Authorization for Administration of Medication for In-School Use and on School Trips* for those students who request permission to carry and administer their own medication (prescription and over-the-counter) on school trips.

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