Manhasset Public Schools
Health Offices

PROVIDER ATTESTATION AND PARENT PERMISSIONS FOR INDEPENDENT MEDICATION CARRY AND USE

Directions for the Health Care Provider:
A **provider order** and **parent/guardian permission** are needed for a student to carry and use medications that require rapid or daily medication to prevent negative health outcomes. These medications should be identified by checking the appropriate boxes below.

Student Name: _____ **Grade:** _____ **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 without supervision by school staff. This order applies to the medications checked below:

This student is diagnosed with:

- ❑ Allergy to _____ and requires Epinephrine Auto-injector
- ❑ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication
- ❑ Diabetes and requires Insulin/Glucagon/Diabetes Supplies
- ❑ Other Diagnosis _____

List names and dosages of medication:

_____

_____

Stamp:

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 without supervision by school staff.

Signature: _____ Date: _____

Parent/Guardian Phone No. _____

Email: SSHealthOffice@manhassetschools.org
Phone: 516-267-7520 **Fax:** 516-267-7524