



West Irondequoit Central School District

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Parent and Prescriber's Authorization for **Independent Carry and Administer** of Medications in School and School-Sponsored Events

Student Name: _____ School: _____

Date of Birth: _____ Grade: _____ School Year: _____

A. To be completed by parent or guardian:

I agree that my child uses the notated medication effectively and may carry and use this medication in school and at school-sponsored events. I assume responsibility for ensuring that my child: carries non-expired medication, administers it and stores it correctly, and understands that sharing it with others is not permitted. I understand that this must be renewed annually or whenever there is a change in the original prescription.

Signature (Parent or Guardian): _____

Address: _____

Phone- Home: _____ Work: _____ Date: _____

B. To be completed by the licensed health care provider:

I request that my patient, as listed below, receive the following medication:

Name of Student: _____ Date of Birth: _____

Diagnosis: _____

Name of Medication: _____

Prescribed Dosage, Frequency, and Route of Administration: _____

Time to be Taken During School Hours: _____ Duration of Treatment: _____

Possible Side Effects/Adverse Reactions: _____

In my judgement, this student is responsible and may carry and use this medication independently in school and at school-sponsored events. I attest that this student has demonstrated to me that he/she can self-administer the medication listed safely and effectively.

Name of Licensed Prescriber (please print): _____

Address: _____ Phone number: _____

Licensed Prescriber's Signature: _____ Date: _____

WELCOME. NURTURE. INSPIRE.