CENTRAL ISLIP UNION FREE SCHOOL DISTRICT

AUTHORIZATION FOR MEDICATION ADMINISTRATION IN SCHOOL

(To be completed by Parent/Guardian **AND** Medical Prescriber**)**

Part A (Completed by Parent/Guardian)

I give permission for my child _____DOB_____
to be given medication prescribed by the Licensed Health Care Provider **(LHCP).** The medication will be provided in an original labeled container. I, the parent/guardian, authorize the school to assist my child in taking this medication. I agree that I will not hold liable any member of the school staff of official capacity assisting my child.

Signature of Parent/Guardian: _____ Date: _____

Parent/Guardian Contact Numbers:

(H)_____ (C) _____ (W) _____

Parent/Guardian Permission for Independent Use and carry

I agree that my child may carry and use this medication independently at school or any school sponsored activity.
Staff intervention/support is needed only during an emergency.

Signature of parent/Guardian: _____ Date: _____

Part B (Completed by MD or Licensed Healthcare Provider) - VALID FOR 1 YEAR

Student Name_____ DOB_____ Grade_____

MDI (Inhalers)

Diagnosis_____ Medication_____ Dosage_____

Frequency_____Time_____Route_____ Duration: _____

Is the MDI needed before Gym/Exercise? _____YES _____NO

Can medication be skipped for field trips? _____YES _____NO

Side Effects_____ Discontinue with Symptoms ____Yes ____No

INDEPENDENT USE AND CARRY (Student Should Be Able to self-carry medication for Sports and Field Trips)

The self-directed student may carry their own inhaler/EpiPen/other medication? _____Yes _____No

**The school nurse will assess the student based on the following criteria: able to identify medication by name, color, dose, time, purpose, and schedule. Student must demonstrate responsibility.

OTHER MEDICATIONS (For example: Epipen, Benadryl, Motrin, etc.)

Diagnosis_____ Medication_____ Dosage_____

Frequency_____ Time_____ Route_____ Duration: _____

Can medication be skipped for field trips? _____YES _____NO

Side Effects_____ Discontinue with Symptoms ____Yes ____No

INDEPENDENT USE AND CARRY *(Student Should Be Able to self-carry medication for Sports and Field Trips)*

The self-directed student may carry their own inhaler EpiPen/other medication? _____Yes _____No **The school nurse will assess the student based on the following criteria: able to identify medication by name, color, dose, time, purpose, and schedule. Student must demonstrate responsibility.

Diagnosis_____ Medication_____Dosage_____

Frequency_____ Time_____ Route_____ Duration: _____

Can medication be skipped for field trips? _____YES _____NO

Side Effects_____ Discontinue with Symptoms ____Yes ____No

INDEPENDENT USE AND CARRY *(Student Should Be Able to self-carry medication for Sports and Field Trips)*

The self-directed student may carry their own inhaler/EpiPen/other medication? _____Yes _____No

The school nurse will assess the student based on the following criteria: able to identify medication by name, color, dose, time, **purpose, and schedule. Student must demonstrate responsibility.

MD/DO/NP/PA Signature_____ **Date**_____

*****MUST STAMP*****

(with LHCP NAME, ADDRESS, PHONE NUMBER)

Medication Administration Daily Log For:

(To Be Completed for Each Medication and Dosage Change)

Name of Student: _____ School Year: _____

Date of Birth: _____ Sex: ___ Grade/Teacher: _____ Name of School: _____

Parent/Guardian: _____ Best Phone #: _____

Medication: _____ Dosage: _____ Start Date: _____ Stop Date: _____

Route: _____ Frequency: _____ Time(s) Given in School: _____ Known Allergies: _____

Directions: Initial with time of administration; a complete signature and initials of each person administrating medications should be included below.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Sept																															
Oct																															
Nov																															
Dec																															
Jan																															
Feb																															
Mar																															
Apr																															
May																															
June																															

Comments: _____

_____

_____

Initial: _____ Name: _____ Initial: _____ Name: _____

_____ _____ _____ _____

_____ _____ _____ _____

Codes:

A- Absent	*D- Early Dismissal*
F- Field Trip	*H- Holiday*
O- Out of Medication	*R- Refused*
W- Withheld Dosage	*X- No School*