

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)

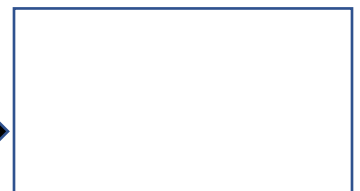
The self-directed student may carry their own inhaler/EpiPen/other medication? _____ Yes _____ No

****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 administering 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