

Hastings-On-Hudson Public Schools

Health Offices

Hillside Elementary School
120 Lefurgy Avenue
Hastings-On-Hudson, NY 10706
(Tel) 914 478-6280
(Fax) 914 478-3795

Farragut Middle School
27 Farragut Avenue
Hastings-On-Hudson, NY 10706
(Tel) 914 478-6226
(Fax) 914 478-6340

High School-Middle School
27 Farragut Avenue
Hastings-On-Hudson, NY 10706
(Tel) 914 478-6225
(Fax) 914 478-6340

Parent and Prescriber's Authorization for Administration of Medication in School

A. To be completed by parent/guardian:

I request that my child _____ grade _____ receive the medication(s) as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in a properly labeled original container from the pharmacy. *(In the event of an emergency the district's stock Albuterol may be used when the student's prescription is empty)*

Parent/Guardian Signature: _____ (Tel #) _____

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

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

Student Name: _____ DOB: _____

Diagnosis: _____

MEDICATIONS MUST BE ORDERED IN PROPER DOSAGE NOTATION (i.e. mg, concentration) TO BE ACCEPTED

Medication: _____	Dosage: _____	Frequency: _____	Route: _____
Medication: _____	Dosage: _____	Frequency: _____	Route: _____
Medication: _____	Dosage: _____	Frequency: _____	Route: _____
Medication: _____	Dosage: _____	Frequency: _____	Route: _____
Medication: _____	Dosage: _____	Frequency: _____	Route: _____
Possible Side Effects: _____			

****PLEASE COMPLETE THIS SECTION FOR SELF CARRY STUDENTS****

Health Care Provider Permission for INDEPENDENT USE and CARRY (not applicable for grades K-4)

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 an Epinephrine Device
- ☐ Allergy and requires oral antihistamine
- ☐ 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)

MD 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.

PARENT SIGNATURE: _____ Date: _____

Licensed Prescriber: _____ Date _____ Stamp:

Name and Title (print): _____

Address: _____

MD SIGNATURE: _____