Syosset Central School District

AUTHORIZATION FOR INDEPENDENT MEDICATION CARRY AND USE

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

Student name:_____ **D.O.B.:**_____

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. Staff intervention and support is needed only during an emergency.

This order applies to the medications checked below:

- ☐ Allergy and requires Epinephrine Auto-injector
- ☐ Asthma and respiratory condition and requires inhaled Respiratory Rescue Medication
- ☐ Diabetes and requires Insulin/Glucagon/Diabetes Supplies

Name of medication:_____

Dosage:

(1) Amount to be given: _____

(2) Time to be given: _____

Side effects:

(1) To report: _____

(2) To expect: _____

Physician's Signature: _____ Date: _____

Physician's Stamp: Telephone No.:_____

Parent/Guardian Permission for Independent Use and Carry

I agree that my child can use their medication safely and effectively, and may carry and use this medication independently at any school/school sponsored activity. Staff interventions and support is needed only during an emergency.

Parent/Guardian Signature: _____ Date:_____

Parent/Guardian Telephone No.:_____

Updated Sept. 2023