CENTRAL ISLIP UNION FREE SCHOOL DISTRICT
AUTHORIZATION FOR MEDICATION ADMINISTRATION IN SCHOOL
(To be completed by Parent/Guardian **and** Medical Prescriber**)**

Part A (Parent/Guardian)
I give permission for my child ________________________DOB__________ Grade/Teacher______ 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.
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Part B (Completed by MD/DO/NP/PA)
Student Name___________________________ DOB_________ Grade/Teacher______________
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 for Sports)
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
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 for Sports)
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 for Sports)
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 NAME, ADDRESS, PHONE NUMBER**