COMMACK PUBLIC SCHOOLS
COMMACK, NEW YORK
DEPARTMENT OF HEALTH SERVICES

REQUEST FOR ADMINISTRATION OF MEDICATION DURING SCHOOL DAY

Authorization for Administration of Medication

NAME: ____DATE: ________________

A. To be completed by the parent or guardian:

I request that my child ___________________________grade _______ receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication.

SIGNATURE (Parent or Guardian): ____

Address: ____

Telephone: Home ________________________________Work _________________________ Date ________________________

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

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

Name of Student: ____Date of Birth: _________________________

Diagnosis: ____

Name of Medication: ____

____
Prescribed Dosage, Frequency and Route of Administration

____ ___________________________________
Time to be Taken During School Hours Duration of Treatment

Possible Side Effects and Adverse Reactions (if any):
____

____

Other Recommendations: ____

SIGNATURE ____ Date: _____________________________

PHYSICIAN'S STAMP:

HEALTH CARE PROVIDER PERMISSION FOR INDEPENDENT USE AND CARRY

Please see reverse side of this form for information and signatures

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.

SIGNATURE: ____ Date: ___________________________________

Health Care Provider Permission for Independent Use and Carry

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 Epinephrine Auto-injector
- ☐ 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)

SIGNATURE: ____ Date: ______________________________

PHYSICIAN'S STAMP: