

CENTRAL ISLIP SCHOOL DISTRICT  
**AUTHORIZATION FOR MEDICATION ADMINISTRATION IN SCHOOL**

(To be completed by parent/guardian **and** medical prescriber)

**Part A (Completed by MD or LHCP)**

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

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MD /LHCP Signature \_\_\_\_\_ Date \_\_\_\_\_

\*\*MUST STAMP WITH NAME, ADDRESS, PHONE NUMBER\*\*

**Part B (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.

Signature of parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_