

**IRVINGTON UNION FREE SCHOOL DISTRICT
SCHOOL HEALTH SERVICES**

Dows Lane Elementary
914-269-5150; f:914-591-6863

Main Street School
914-269-5250; f:914-591-3099

Middle School
914-269-5350; f:914-591-2643

High School
914-269-5450; f:914-591-1956

MEDICATION AUTHORIZATION FORM

Student Name: _____ **DOB/Grade:** _____ **Teacher/HR:** _____

Parent/Guardian Name: _____ **Telephone:** _____

To Be Completed By Health Care Provider

Diagnosis (must be included) and Medication Name	Dose	Route	Time	Sign, Symptom or Situation	<input checked="" type="checkbox"/> applicable boxes below
_____ Dx:					<input type="checkbox"/> Independent Student <input type="checkbox"/> Supervised Student <input type="checkbox"/> Nurse Dependent
_____ Dx:					<input type="checkbox"/> Independent Student <input type="checkbox"/> Supervised Student <input type="checkbox"/> Nurse Dependent
_____ Dx:					<input type="checkbox"/> Independent Student <input type="checkbox"/> Supervised Student <input type="checkbox"/> Nurse Dependent

Prescriber please use codes below for each medication ordered:

Independent Student	I attest that this student has demonstrated to me that they can self-administer the medication(s) noted above 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. Controlled substances are NOT eligible for self-administration under any circumstance.
Supervised Student	I attest that this student is self-directed regarding their medication. They understand the purpose, name, amount, time and effect of taking or not taking the medication. Recognizes the medication and refuses to take it inappropriately. The school nurse , or designated person in the absence of the school nurse, will assist the student in taking his/her medication.
Nurse Dependent	I attest that this student is non-self-directed. A nurse must administer the student's medication.

Name/Title of Licensed Prescriber (Print) _____ **Date** _____ **STAMP**

Prescriber's Signature _____ **Phone** _____

To Be Completed By Parent

I give permission for the above medication to be administered to my child as ordered by my healthcare provider. I will furnish the medication in the original pharmacy container, properly labeled with directions and dosage, or original over-the-counter medication container/packaging with my child's name on it.

In addition, I give my permission along with provider consent, for my child to self-administer and self-carry medication as indicated above. **My child is independent in taking their medication at school and requires no supervision by the nurse or school staff. I assume responsibility for ensuring that my child is carrying and taking their medication as ordered.** I understand the school may revoke the self-carry/ self-administer privilege if my child proves to be irresponsible or incapable.

Parent/Guardian Signature _____ **Date** _____ **Phone** _____