IRVINGTON UNION FREE SCHOOL DISTRICT
SCHOOL HEALTH SERVICES

Dows Lane Elementary	Main Street School	Middle School	High School
914-269-5150; fax: 914-591-6863	914-269-5250; fax: 914-591-3099	914-269-5350; fax: 914-591-2643	914-269-5450; fax: 914-591-1956

MEDICATION AUTHORIZATION FORM

This form is valid for the current school year for both prescription and over the counter (OTC) medication.
Students may not carry any medication unless indicated on this form.

A. To be completed by parent/guardian:

I request that my child_____ grade ____ receive the medication(s) as prescribed below by our licensed health care prescriber. ALL medication, including OTC, is to be furnished by me in a **properly labeled original container from the pharmacy.**

Parent/Guardian Signature: _____ (Tel #) _____ Date: _____

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

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

Student Name: _____ **DOB**: _____

Diagnosis: _____

Parameters for Medication to be administered: _____

****MEDICATIONS NOT ORDERED IN PROPER DOSAGE NOTATION (i.e. mg, concentration) WILL NOT BE ACCEPTED****

Medication: _____ Dosage:_____Time:_____ Frequency:_____ Route:_____
Medication: _____ Dosage:_____Time:_____ Frequency:_____ Route:_____
Medication: _____ Dosage:_____Time:_____ Frequency:_____ Route:_____
Medication: _____ Dosage:_____Time:_____ Frequency:_____ Route:_____

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
❑ Other_____ which requires rapid administration of _____
(State Diagnosis) (Medication Name)

Signature of Prescriber: _____ Date: _____

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: _____

Licensed Prescriber: _____ Date_____ Stamp:
Name and Title (print): _____
Signature: _____
Address: _____