IRVINGTON UNION FREE SCHOOL DISTRICT
SCHOOL HEALTH SERVICES

Dows Lane Elementary	Main Street School	Middle School	High School
914-269-5150; f:914-591-6863	914-269-5250; f:914-591-3099	914-269-5350; f:914-591-2643	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	☑ applicable boxes below
					☐ Independent Student ☐ Supervised Student ☐ Nurse Dependent
					☐ Independent Student ☐ Supervised Student ☐ Nurse Dependent
					☐ Independent Student ☐ Supervised Student ☐ 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 _____