HALF HOLLOW HILLS HIGH SCHOOL EAST

50 Vanderbilt Pkwy.
Dix Hills, NY 11746
Health Office: Ph. 631-592-3101/3127 Fax 631-592-3976/3977

STUDENT'S NAME____________________________**DOB** ___________ **Grade**____

Dear Parent:
In order for any medication to be administered in school, state law requires a written request from your family physician indicating the dosage, frequency and side effects of the medication.

The school nurse must also have on file, a written request from the parent to administer the medication. A new form must be filled out for each change of medication or change of dosage. Each school year the entire procedure must be repeated.

1.To be completed by the parent or guardian:

A. I request that the school nurse, or her alternate, administer the medication as requested by my physician to my child.
B. I will deliver the medication directly to the school nurse in **a container labeled by the pharmacist** and indicating the name of the medication prescribed.

****Signature of Parent or Guardian:** ____________________________________

Date ________ Relationship______________ Phone: Home ___________Work_________

2. To be completed by physician:

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

- Specific Diagnosis____
- Name of Medication____
- Dosage amount to be given____
- Time to be given / Frequency____
- Duration of regime____
- Side Effects to report / expect____

****Physician's Signature** ____________________________ Date ___________________

Phone: ____________________ **STAMP PLEASE** :

****A NOTE TO PARENT & PHYSICIAN**: Please complete the reverse side of (or attachment to) this form if the student self-carries and self-administers medications.

PROVIDER AND PARENT PERMISSIONS
REQUIRED FOR INDEPENDENT MEDICATION USE AND CARRY

Directions for the Health Care Provider: This form may be used as an addendum to a medication order which does not contain the required diagnosis and attestation for a student to independently use and carry their medication as required by NYS law. A **provider order** and **parent/guardian permission** is needed in order for a student to carry and use medications that require rapid administration to prevent negative health outcomes. These medications should be identified by checking the appropriate boxes below.

Student Name: ______________________________ **DOB:** ________________

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: ________________

Parent/Guardian Permission for Independent Use and Carry:
I agree that my child can use their medication effectively and may use and carry this medication independently at any school/school sponsored activity with no supervision by school staff.

Signature: ____________________________ Date: ________________

Please return to School Nurse attached to the STUDENT HEALTH EXAMINATION FORM