ROSLYN SCHOOL DISTRICT
ROSLYN, NY

MEDICATION AUTHORIZATION FOR SELF-CARRY AND USE RELEASE FORM

Directions for the Health Care Provider: A **provider order** and **parent/guardian permission** are 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:** _____**Grade**_____

Section 1: Health Care Provider Authorization and Signature

Health Care Provider Permission for Independent Use and Carry

I attest that this student has demonstrated to me that he or she 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. Staff intervention and support is needed only during an emergency.

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

Name of Medication(s):_____

Dosage amount to be given:_____ Time to be given:_____

Provider's Signature:✗_____ **Date:**_____

Provider's Stamp: Phone:_____

Section 2: Parent /Guardian Consent and Signature

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. The student will carry medication in a properly labeled container with their name on it. Staff intervention and support is needed only during an emergency.

Parent/Guardian Signature:✗_____**Date:**_____

Address_____ Primary Phone: _____

NOTE:It is the parent's responsibility to monitor on an ongoing basis that student is carrying and taking medication as directed.