AUTHORIZATION FOR ADMINISTRATION OF MEDICINE AT SCHOOL AND AFTER-SCHOOL ACTIVITIES & AUTHORIZATION FOR SELF-ADMINISTRATION / SELF-CARRY OF MEDICATION

The New Hyde Park – Garden City Park School District permits a responsible, trained student to carry and / or self-administer medication for asthma, severe allergic (anaphylactic) reaction, or diabetes on his / her person for immediate use in a life-threatening situation with written order of physician, parent request, school nurse and principals approvals.

PHYSICIAN / PRESCRIBING HEALTH CARE PROVIDER ORDER

Name of Student _____ Date of Birth _____

Address _____ Grade _____

Condition for which the medication is administered _____

Name of medication, dose and method administered _____

Time or indication for administration _____

Is this a controlled drug? ☐ Yes ☐ No

Side effects to be noted / reported _____

Other recommendations _____

Duration (dates) of administration: From_____ To _____ (Limit of one school year)

_____ _____ _____Office Stamp
Physician Signature *Print Name* *Date*

In my opinion, this student shows capability to carry and self-administer the above medication. The student has been trained in the use of the prescribed medication(s) and is judged to be capable of carrying and self-administering the medication(s).

PARENT / GUARDIAN AUTHORIZATION

I give my consent and authorize the school nurse to administer the above medication to my child as ordered by the physician.

I am the parent / guardian of the child named above and I am acting on my own behalf of this minor child. We hereby authorize and agree to hold The New Hyde Park – Garden City Park School District and its officers and employees harmless for the administration of this medication.

I understand that The New Hyde Park – Garden City Park School District be immune from all liability for acts arising out of the administration of medication in accord with the terms of this document except in the case of gross negligence or willful and wanton misconduct.

In addition to the immunity described above, in exchange for The New Hyde Park – Garden City Park School District's agreement to assume responsibility for the administration of medication as described in this permission statement, we hereby release any and all claims that we may lawfully release at this time for acts or omission arising out of the administration in accord with this grant of permission.

_____ _____
Parent Signature *Date*

PARENT / GUARDIAN REQUEST TO CARRY / SELF-ADMINISTER

I request that my child, named above, be permitted to: ☐ carry ☐ self-administer the above ordered medication. I take responsibility for this permission. I understand that the medication must be in the original pharmacy container, labeled with name of student, prescribing health care provider, and medication name, date of original prescription, strength and dose of medication, and directions for use. I will also provide extra medication with a physician Authorization of Medication Form to be kept in the school nurse's office for emergencies. I understand that The District will not be responsible for tracking medications that my child is permitted to carry. I also understand that if my child administers a permitted medication that he/she carries to himself/herself, it will be reported to the school nurse by the child.

I understand that the school, after consultation with the parent(s) may impose reasonable limitations or restrictions upon a student's possession and/or self-administration of said emergency medication relative to the age and maturity of the student, if the student shows signs of irresponsible behavior or there is a safety risk, or other relevant consideration.

_____ _____
Parent Signature *Date*