OFFICE OF STUDENT HEALTH SERVICES
PATCHOGUE-MEDFORD SCHOOLS
181 Buffalo Avenue
Medford, NY 11763
Telephone (631) 687-6420

REQUEST FOR MEDICATION INDEPENDENT USE AND CARRY

Student's Name ________________________ Grade ______ Date _____________

PHYSICIAN STATEMENT

Condition requiring this medicine: ____________________________________
Name of Medication: ____
Dosage: ______________________________ Frequency: ___________________
Time(s) of day to be taken: ____
Any side effects? Yes No If yes, what? ____________________________

The student is__/is not___ considered capable to self- administer and carry this medication in school and/or during school trips/sports*(see below)

Permission for Independent Use and Carry
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 _______________

Parent/Guardian Permission for Independent Use and Carry
I agree that my child can use their medication and may carry and use this medication independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency.

Parent Signature______________________________________Date________________

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 above at any school/school sponsored activity. Staff intervention and support is needed only during an emergency.

Physician's signature: ____
Date: _________________ Physician's telephone number _____________________

Affix Physician's stamp here: