Hastings-On-Hudson Public Schools
Health Offices

Hillside Elementary School
120 Lefurgy Avenue
Hastings-On-Hudson, NY 10706
(Tel) 914 478-6280
(Fax) 914 478-3795

High School-Middle School
27 Farragut Avenue
Hastings-On-Hudson, NY 10706
(Tel) 914 478-6224
(Fax) 914 478-6340

Parent and Prescriber's Authorization for Administration of Medication in School

A. To be completed by parent/guardian:
I request that my child__________________________ grade____ receive the medication(s) as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in a properly labeled original container from the pharmacy. (*In the event of an emergency the district's stock Albuterol may be used when the student's prescription is empty)*
Parent/Guardian Signature:_____________________________ (Tel #)___________________

B. To be completed by the licensed health care prescriber:
I request that my patient, as listed below, receive the following medication(s):
Student Name:_______________________________ **DOB**:____________
Diagnosis:____

****MEDICATIONS MUST BE ORDERED IN PROPER DOSAGE NOTATION (i.e. mg, concentration) TO BE ACCEPTED****

Medication:__________________________ **Dosage:**______________________ **Frequency:**__________________**Route:** _______
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Medication:__________________________ **Dosage:**______________________ **Frequency:**__________________ **Route:**_______
Medication:__________________________**Dosage:**______________________ **Frequency:**__________________**Route:**________
Possible Side Effects:____

Health Care Provider Permission for Independent Use and Carry (not applicable for grades K-4)

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 carry and use this medication independently at any school/school sponsored activity with no supervision by school staff.

Signature: _______________________________ Date: ________________

Licensed Prescriber:___________________________ **Date**_________ **Stamp:**
Name and Title (print):__________________________
Signature: ______________________________________
Address:____