Authorization for Self-Carry/Self-Administration of Medicine
At School and School Sponsored Activities
Syosset Central School District

Student Name: _____

Grade: _____ Age: _____ DOB: _____

Student has been instructed in the proper use of her:

☐ Inhaler ☐ Benadryl/EpiPen/Auvi-Q ☐ Insulin Pump ☐ Insulin Pen

In my opinion, the above student shows capability to carry and self-administer the above medication.

_____ Physician's Stamp:
Physician's Signature Date

Parent/Guardian Authorization:

I request that my child, named above, be permitted to carry and/or self administer the above ordered medication. She has been instructed in and understands the purpose, appropriate method and use of her inhaler, Benadryl/EpiPen/Auvi-Q, and/or Insulin Pump/Pen. I understand that she will report to or summon the Nurse if she has used her inhaler or has taken her Benadryl/EpiPen/Auvi-Q or has difficulty with her pump/pen.

I also understand that his privilege may be withdrawn if she shows signs of irresponsible behavior or there is a safety risk, and I will be contacted in that event.

_____ _____ _____
Parent/Guardian Signature Phone Number Date

_____ _____ _____
Student Signature Phone Number Date

Note: This form must be completed in addition to the Medication Permission Request Form and be kept in the student's medical file.

Received in the Nurse's Office: _____

School Nurse Signature

_____

Date