EMERGENCY MEDICATION
AUTHORIZATIONS FOR SCHOOL ADMINISTRATION

Such emergency medications include Epinephrine (for severe allergies); Inhalers (for asthma); and, Insulin/Glucagon (for diabetes).

A HEALTH CARE PROVIDER ORDER and PARENT/GUARDIAN PERMISSION is needed in order for a student to self-carry and use medications that require rapid administration.

The following information should be completed by the student’s medical provider and parent/guardian:

**TO BE COMPLETED BY HEALTH CARE PROVIDER:**

I request that my patient, as listed below, receive the following medication(s):

NAME:_____________________________________ DOB:____/____/______ GRADE:________

<table>
<thead>
<tr>
<th>MEDICATION(S)</th>
<th>DOSAGE ROUTE</th>
<th>FREQUENCY TIME</th>
<th>REASON FOR MEDICATION</th>
<th>DURATION OF TREATMENT</th>
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Possible Side Effects/Adverse Reactions:_____________________________________________________

*(____) I attest that this student has been instructed and has demonstrated to me that he/she can self-administer the medication(s) listed above safely and effectively; and, they 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, either on his/her person or to keep in his/her locker.

(____) Yes, student may carry and self-administer medication

(____) No, I do not attest to the above-mentioned statement. Student’s medication should be kept in health office.

Name of Health Care Provider and Title (please print):_________________________________________________________________________________________  

Health Care Provider’s Signature:____________________________________________________Date:____/____/____

Address:___________________________________________________________________________________________ Phone:__________________________

**TO BE COMPLETED BY THE PARENT OR GUARDIAN:** I request that my child __________________________ receive the medication(s) as prescribed above by our licensed health care provider.

*(____) 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.

Parent/Guardian Signature:________________________________________Date:____/____/____

Address:________________________________________________________________________ Phone:__________________________

Bethlehem Central School District Health Services

High School Phone # 439-4967 Fax # 475-9243  Middle School Phone # 439-7705 Fax # 439-0513

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