SMITHTOWN CENTRAL SCHOOL DISTRICT

Self- Medication Form

Student Name: _____ **DOB:** _____

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 below safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at school or at any school sponsored activity.

This student is diagnosed with:

- ☐ An Allergy which requires Epinephrine Auto-injector and/or Benadryl
- ☐ Asthma or respiratory condition which requires Inhaled Respiratory Rescue Medication
- ☐ Diabetes which requires Insulin/Glucagon/Diabetes Supplies
- ☐ _____ which requires administration of _____
  (Diagnosis) (Medication)

Physician's Signature: _____ Date: _____

Physician's Stamp:

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 school or at any school sponsored activity. We hereby acknowledge that we shall hold harmless the School District and its personnel in the event of any illness or injury to the student caused by the improper administration of medication or the student's failure to self-administer the medication, as instructed.

Parent's Signature: _____ Date: _____

Note: This form must be completed in addition to the routine district medication form

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