LEVITTOWN PUBLIC SCHOOLS

Levittown Memorial Education Center
150 Abbey Lane
Levittown, New York 11756

Ms. Michele Ortiz, **Director**
World Language and ENL
Health Services

PROVIDER ATTESTATION AND PARENT PERMISSIONS FOR INDEPENDENT MEDICATION CARRY AND USE

Directions for the Health Care Provider: This form may be used as an addendum to a medication order which does not contain the required diagnosis and attestation for a student to independently carry and use their medication as required by NYS law.
A **provider order** and **parent/guardian permission** are needed in order for a student to carry and use medications that require rapid administration to prevent negative health outcomes. These medications should be identified by checking the appropriate boxes below.

Student Name: ___________________________DOB: ____________________

Health Care Provider Permission for Independent Use and Carry

I attest that this student has demonstrated to me that he or she 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. Staff intervention and support is needed only during an emergency. 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)

Dr. 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. Staff intervention and support is needed only during an emergency. I will advise my child to notify the school nurse anytime they self-administer at school.

Signature: ____________________________________ Date: ___________________

Please return to School Nurse:

School Nurse:		School:
Phone #:	Fax:	Email:

Dr. Stamp: