Arlington High School Health Office
1157 Rt. 55
LaGrangeville, NY 12540

Phone – 845-486-4860 Ext - 31313
Fax – 845-350-4182

EMERGENCY MEDICATION DOCTOR' S ORDER FORM

(FOR SELF CARRY/SELF ADMINSTERED MEDICATIONS)

A **provider order** and **parent/guardian permission** are **REQUIRED** for all medications administered at school and/or school sponsored activities. **Marching Band / Winter Guard / Winter Percussion members will not be permitted to participate without current orders.**

The below **provider attestation** is **REQUIRED** for a student to ***independently carry and use a medication*** such as inhaled respiratory rescue medication, epinephrine auto injector, insulin, glucagon and diabetes supplies, or other medications requiring rapid administration along with parent/guardian permission to allow this option. Students who participate in Marching Band / Winter Guard / Winter Percussion are required to be able to independently carry and administer these medications.

Student Name_____ **DOB**_____ **Grade**_____

Health Care Prescriber Medication Order.

Diagnosis: _____ **Diagnosis:** _____

Medication: _____ **Medication:**_____

Dose & Route: _____ **Dose & Route**:_____

Time: _____ **Time:** _____

Provider Permission for Self- Administration and Carry:

❒ **No** ❒ **Yes**, I attest that this student has demonstrated that they can self-administer the medication(s) listed above effectively and may carry and use this medication independently at any school/school sponsored activity. Staff intervention and support are needed only during an emergency.

Provider's Signature_____ Date _____

Provider's Name_____

Provider's Address _____

Phone_____ Fax_____

Provider Stamp

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Parent/Guardian Permission for Medication

❒ I agree that my child can self-administer and will carry the medication as prescribed above.

Parent/Guardian Signature_____ Date_____