



**NORTH COLONIE CENTRAL SCHOOLS**

91 Fiddlers Lane  
Latham, NY 12110

**SHAKER HIGH AND JR. HIGH SCHOOL FORMS**

**AUTHORIZATION FOR A STUDENT TO USE AND CARRY MEDICATION(S) IN SCHOOL**

**Shaker High Fax 785-2767 or 783-5905**

**Shaker Jr. High Fax 785-2768**

1. All Medications (prescription and non-prescription) must be prescribed by a licensed prescriber. Prescription medication must be in the original container, labeled with the student's name, drug name, frequency of administration, dosage, date prescribed and prescriber's signature. Non-prescription medication must be in the original labeled container with student's name written on the container.
2. Students are allowed to carry **ONLY** asthma inhalers and allergic reaction medications ie:Epi Pens and/or Benadryl. This form must be completed and returned to the nurse's office to be kept on file.
3. These orders expire at the end of the school year and must be renewed at the beginning of every school year.

Diagnosis \_\_\_\_\_ ICD Code \_\_\_\_\_

A. **Name of Student** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

1. Medication \_\_\_\_\_ Dosage, Frequency, & Route \_\_\_\_\_

2. Medication \_\_\_\_\_ Dosage, Frequency, & Route \_\_\_\_\_

3. Medication \_\_\_\_\_ Dosage, Frequency, & Route \_\_\_\_\_

**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 any school/school sponsored activity with no supervision by school staff. 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)

**Signature of licensed prescriber:** \_\_\_\_\_ **License #** \_\_\_\_\_

**NAME OF LICENSED PRESCRIBER AND TITLE (Please Print):** \_\_\_\_\_

**Address:** \_\_\_\_\_ **NPI #** \_\_\_\_\_

**Date :** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Parent/Guardian Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_