Eastport/South Manor Central School District

149 Dayton Avenue • Manorville, New York 11949 • (631) 801-3000 • Fax (631) 874-6750

JOSEPH A. STEIMEL
Superintendent of Schools

Name: _____ **DOB:** _____ **Grade:** _____

MEDICATION FORM FOR SCHOOL YEAR 2020-2021

DIAGNOSIS: _____

ALLERGY: _____

Medication Name	Dose	Frequency	Route	Time	Possible Side Effects

MD Signature: _____ **Date:**_____

I request that my child, _____receive the medication/s as prescribed above by our licensed health care provider. The medication is to be furnished by me in the properly labeled, original container from the pharmacy, I understand that the school nurse, or other designated person, will administer the medication.

Parent/Guardian Signature: _____ **Date:** _____

FOR SELF MEDICATION PERMISSION: The above child has been instructed in the proper use of the above medications/procedures. I request that this child be able to carry the medication on his/her person, to keep it in his/her locker or PE locker as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency or use.

MD Signature: _____ **Date:** _____

Parent/Guardian Statement: I hereby agree not to hold the Eastport South Manor School District liable for any matter relating to the supervision of the self-medication procedure; it being recognized by me that it is not the responsibility of the school district to administer or supervise the administration of medication to students deemed self-manage.

Parent/Guardian Signature: _____ **Date**: _____

****HEALTH CARE PROVIDER STAMP NEEDS TO BE AFFIXED****