HUDSON FALLS CENTRAL SCHOOL DISTRICT
Hudson Falls, NY 12839, (518) 747-2121

AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION AT SCHOOL AND AFTER-SCHOOL ACTIVITIES

A. To be completed by the licensed healthcare provider:

(Student's name): _____ has been instructed in the

proper use of the following insulin pump: _____

IN MY PROFESSIONAL OPINION, THIS STUDENT SHOULD BE ALLOWED TO CARRY AND USE THE ABOVE INSULIN PUMP BY HIM/HERSELF.

_____ _____
(Licensed Provider's Signature) (Date)

B. To be completed by parent or guardian:

I request that my child _____ be permitted to self administer her/his insulin pump on his/her person, as I consider him/her responsible. The student has been instructed in and understands the purpose, appropriate method, frequency and use of his/her insulin pump. The student understands that he/she is responsible and accountable for carrying and using his/her insulin pump.

(Parent/Guardian Signature) (Date)

The licensed provider's statement and parent request are accepted. The student will be permitted to use the insulin pump. The parent will be contacted as soon as possible in the event of irresponsible behavior or safety risk.

(School Nurse Signature) (Date)

Date form received in health office: _____