Medication in School

New York State Law requires that ***all*** medications given in school, including non-prescription drugs, shall be prescribed by a licensed prescriber on an individual basis as determined by the child's health status.

Written orders for prescription and non-prescription drugs should be made on the form following this page. Local doctors have a supply of these forms. If you are seeing an out-of-town doctor, take the form with you.

Be sure that both doctor and parent parts are completed.

If your child needs to carry and self-administer medicine, such as an inhaler, the prescriber must also complete the reverse of the form.

Medication orders must be renewed annually or sooner if there is a change in medication or dosage.

TICONDEROGA CENTRAL SCHOOL DISTRICT

AMHERST AVENUE
TICONDEROGA, NY 12883

PARENT & PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

A. TO BE COMPLETED BY THE PARENT OR GUARDIAN:

I request that my child _____ grade _____ receive the medication as prescribed below by our licensed health care prescriber. 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, in the case of the absence of the school nurse, will administer the medication.

Signature (Parent or Guardian): _____

Address: _____

Telephone: Home _____ Work _____ Date: _____

B. TO BE COMPLETED BY THE LICENSED HEALTH CARE PRESCRIBER:

I request that my patient, as listed below, receive the following medication:

Name of Student: _____ Date of Birth _____

Diagnosis: _____

Name of Medication: _____

Prescribed Dosage, Frequency and Route of Administration:

_____

Time to be Taken During School Hours: _____

Duration of Treatment: _____

Possible Side Effects and Adverse Reactions (if any): _____

_____

Other Recommendations _____

_____

Name of Licensed Prescriber and Title (please print): _____

Prescriber's:

Signature: _____ Date: _____

Address: _____ Phone: _____

(over)

TICONDEROGA CENTRAL SCHOOL DISTRICT

SELF-MEDICATION RELEASE FORM

DATE: _____

CHILD'S NAME: _____ has been instructed in the proper use of the following medical procedures: _____

_____

We (physician's signature) _____

and (parent/guardian signature) _____

request that (child's name) _____ be permitted to carry the medication on his/her person or to keep same in his/her locker or P.E. locker, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use.

Note: This form must be completed in addition to the routine district medication form for those students who request permission to carry their own medication on campus or keep this medication in a locker or P.E. locker.