PLAINVIEW-OLD BETHPAGE CENTRAL SCHOOL DISTRICT
PLAINVIEW, NY 11803

OFFICE OF THE SCHOOL NURSE

Dear Parents/Guardians:

Under certain circumstances, it may be necessary for your child to take MEDICATION, EITHER PRESCRIPTION OF NON-PRESCRIPTION during the school day. Following are the New York State laws regarding the administration of all medications.

1. A **written** request from your family physician must accompany the medication indicating the dosage, frequency, time, duration and any side effects of the medication.

2. A **written** request from the parent to administer the medication must also accompany the medication. A new form **MUST** be filled out by the family physician and written permission obtained from the parent for any **CHANGE OF MEDICATION OR DOSAGE.** New medication permission forms are required each school year.

3. Prescription medication must come in the original pharmacist's container. Request that the pharmacist give you a second identically labeled container for school. This is required for medications to be sent on field trips. **PARENTS** MUST BRING THE MEDICATION TO THE NURSE.

4. Non-prescription (over-the-counter) medications must also be brought to school in original sealed containers. **These are to be small containers** so that they can be sent on field trips and comply with medication storage laws in the Health Office.

5. Children may never bring **medicated cough drops** or any other medication to school. These precautions are advocated to protect all children in the school, as well as your child, and to comply with the directives of the State Education Department.

Under no circumstances will medication be given if the above requirements are not met. Physician or parental permission by phone is not permissible. Permission forms may be obtained from the School Nurse.

At the end of the school year **PARENTS** must pick up all medication.

Thank you for your cooperation in this matter.

PLAINVIEW-OLD BETHPAGE CENTRAL SCHOOL DISTRICT

PARENT AND HEALTHCARE PROVIDER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

A. To be completed by the Parent of Guardian:

I request that my child _____(Date of Birth:_____) receive the Medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy*. I understand that the school nurse or her designee, in the event of her absence, will assist the child.

B. To be completed by the Private Healthcare Provider:

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

Name of Student_____ Date of Birth_____

Diagnosis_____

MEDICATION	DOSAGE	FREQUENCY TO BE TAKEN	ROUTE OF ADMINISTRATION

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

_____

Prescriber's Signature & Stamp _____ Date_____

Address_____ Phone _____

*Medication must be in original pharmacy labeled container with specific orders and name of medication.
*Medication and refills must be brought to school by parent, guardian or responsible adult.

This medication order is valid for the current school year and summer school as needed.