TO: PARENT–GUARDIAN

FROM: HEALTH SERVICES

RE: MEDICATION

Some pupils require daily medication. If possible, this should be given at home (for example, three (3) doses may be given: before school, on return from school and at bedtime.) However, if medicine (pills, liquid, etc.) is necessary during the school day, the following conditions apply:

1. The school must receive a written physician's order with identifying data, name of the medication, details about the product and possible side effects and any activity restrictions. (A form is attached.)

2. A written parent request (included in the form) must also be submitted. Parent permission must be renewed each year.

3. Parent is responsible for delivering the medication to school in a properly labeled original container. Medicine will be stored by the school nurse or principal and administered as directed.

These conditions apply to all medicine taken in school, even if taken for only one day. Medication found in a student's possession must be confiscated.

School nurses and other staff dispense medication, such as aspirin, ONLY WITH A WRITTEN ORDER IN PLACE. Compliance with any other requests is contrary to good health practice and is illegal under the Nurse Practice Act and State Education Law.

2021-2022 SCHOOL YEAR

YONKERS PUBLIC SCHOOLS

FAX; 914-337-8878

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

A. To be completed by the student's parent or guardian:

I request that my child_____ DOB_____ 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 of Parent/Guardian:_____Date:_____

Address:_____

Telephone: Home:_____Work:_____Cell:_____

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 & adverse reactions (if any):_____

_____

Other Recommendations/activity restrictions (e.g. gym):_____

_____

Patient is self-directed and may self-administer medication ***YES*** ***NO***

Prescriber's Signature: _____ **Date:**_____

Address:_____ **Telephone #:**_____

Physician Stamp