

# Putnam Valley Central School District

## Student Medication Policy

Medication of any kind (prescription drugs &/or over the counter medications such as Tylenol, Advil, Tums, cough mixtures/drops, anti-histamines, etc.) cannot legally be dispensed to any child in school without a doctor's order and written parental consent.

Medications that can be taken at home before or after school should be arranged in this manner.

New York State law requires the following procedure to be followed if it becomes absolutely necessary for your child to take medication in school:

- 1) Parent/Guardian must present a **prescription** or **note** from the doctor. (May use form below.)
- 2) A **note** giving the school nurse, teacher, principal or other designated staff member permission to administer the medication **must be signed by the parent/guardian**. (May use form below.)
- 3) An **adult** must bring the medication to school in the **original** (prescription) container.

**No student is to bring or take medication of any kind into school unless the above procedure is followed.** To comply with this law, any student seen with a medication on their person will have the medication taken from him/her and it will be disposed of.

**An adult must pick up all medications by the last day of school.** If not picked up by the end of the school year, the medication **will be discarded** as mandated by state law.

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### Request Form for Administration of Medication to Student in School

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

I request that my child, \_\_\_\_\_, grade \_\_\_\_\_ receive the medication prescribed below by our licensed health care provider.

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

\*\*\*\*\***TO BE COMPLETED BY HEALTH CARE PROVIDER**\*\*\*\*\*

**Diagnosis** \_\_\_\_\_

Name of Medication \_\_\_\_\_ Amount of Dosage \_\_\_\_\_

Time medication is to be administered \_\_\_\_\_ Route \_\_\_\_\_

Duration of Treatment \_\_\_\_\_ Expiration Date of Treatment \_\_\_\_\_

Possible adverse reaction or side effects \_\_\_\_\_

**Student may carry & self-administer medication (asthma & allergic conditions only) YES \_\_\_\_\_ NO \_\_\_\_\_**

This medication may be administered or directed by the principal, teacher, or other school staff personnel to self-directed students in the absence of the school nurse.

Physician's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Physician's Stamp and/or Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**MEDICATION ORDER(S) MAY BE FAXED TO:  
PVHS Health Office @ (845) 526-7802  
PVMS Health Office @ (845) 526-7848  
PVES Health Office @ (845) 526-7849**