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

PROVIDER AND PARENT PERMISSIONS
REQUIRED FOR INDEPENDENT MEDICATION USE AND CARRY

Directions for the Health Care Provider: This form may be used as an addendum to a medication order which does not contain the required diagnosis and attestation for a student to independently use and carry their medication as required by NYS law. A **provider order** and **parent/guardian permission** is needed in order for a student to carry and use medications that require rapid administration to prevent negative health outcomes. These medications should be identified by checking the appropriate boxes below.

Student Name: _____ **DOB:** _____

Health Care Provider Permission for Independent Use and Carry

I attest that this student has demonstrated to me that they can self-administer the medication(s) listed below safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school/school sponsored activity with no supervision by school staff. This order applies to the medications checked below:

This student is diagnosed with:

- ☐ Allergy and requires Epinephrine Auto-injector
- ☐ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication
- ☐ Diabetes and requires Insulin/Glucagon/Diabetes Supplies
- ☐ _____ (State Diagnosis) which requires rapid administration of _____ (Medication Name)

Signature: _____ Date: _____

Parent/Guardian Permission for Independent Use and Carry

I agree that my child can use their medication effectively and may use and carry this medication independently at any school/school sponsored activity with no supervision by school staff.

Signature: _____ Date: _____

Please return to School Nurse:

School Nurse:		School:
Phone #:	Fax:	Email:

This sample resource was created by the New York Statewide School Health Services Center and is located at www.schoolhealthservicesny.com – SN Tool Kit – 6/15