

MEDICATIONS AND SCHOOL

New York State Department of Education regulations state that in order for your child to receive medication at any time during the school year, you must complete certain criteria.

1. Parent/Guardian must present a written consent form
2. Medications must be in the original package/prescription bottle, properly labeled by a registered pharmacist as prescribed by law
3. Present a completed medication form from the prescribing physician

Please be aware that NO medications can be given out by the district's nurses without the above criteria completed. ***This is not to inconvenience you but a state law.***

**Form available on Website

VALLEY STREAM UNION FREE SCHOOL DISTRICT NO. 24

75 HORTON AVENUE VALLEY STREAM, NEW YORK 11581-1499 (516) 434-2830 FAX: (516) 256-0169

**Provider and Parent Permission to Administer Medication at
School/School Sponsored Events**

To Be Completed By Parent

Student Name: _____ DOB: _____

Grade: _____ Teacher/HR: _____ School: _____

I request the school nurse give the medication listed on this plan; or after the nurse determines my child can take their own medications; trained staff may assist my child to take their own medications. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with school staff caring for my child. **(Please attach a small photo of your child to this form.)**

Parent/Guardian Signature

Date

Email

Phone Where We Can Reach You Check if Cell

To Be Completed By Health Care Provider-Valid for 1 Year

Diagnosis _____

Medication _____

Dose _____ Route _____ Time(s) _____

Recommendations _____ ICD Code _____

Note: Medication will be given as close to the prescribed time as possible, but may be given up to one hour before or after the prescribed time. Please advise if there is a time-specific concern regarding administration.

Prescriber please check all that are applicable:

If morning dose is not given at home, nurse may administer morning dose of _____ after verbal or written notification from the parent. Please advise parent to send in additional medication

Medication is required: () on field trips

I assess this student to be self directed* regarding this medication

*The student understands the name, purpose, amount, dose, timing and effect of taking or not taking the medication; can recognize the medication and refuse to take it if it is the wrong medication; can ingest, inhale, apply or calculate and administer the correct dose of the medication independently.

Stamp

Name/Title of Prescriber (Please Print)

Date

Prescriber's Signature

Phone

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