FORT PLAIN CENTRAL SCHOOL DISTRICT

25 HIGH STREET
FORT PLAIN, NEW YORK 13339 - 1365

"OUR AIM IS EXCELLENCE" | TELEPHONE 518-993-4000

Dear Parent/Guardian,

The Education Law of the State of New York Has set up certain requirements for the administration of ANY medication in the school setting. This includes all over the counter medications like Tylenol, Ibuprofen, antibiotic ointment, cough drops, etc. The requirements are listed below.

1. The school nurse must have on file a written request from the family physician in which he/she indicates the frequency and dosage of the prescribed medication. Additional information must be provided by the physician to enable the nurse to can-y out good nursing practice. She must know the condition being treated, the regime of treatment recommendation, and the frequency established by the physician for review of the case.

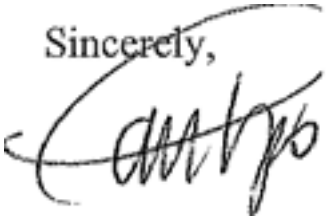
2. The nurse must also have on file a WRITTEN request from the parent or guardian to administer the medication as specified by the physician. A verbal request is NOT acceptable from the viewpoint of protection for the nurse and the school.

3. The medication should be delivered directly to the school nurse by the parent or another designated adult. No medication should be sent to school with the student. The temptation to share a single dose is a very real danger. Also this is a good opportunity for the parent and nurse to discuss the student's problem and assess any changes in the condition or the treatment of the student.

On the back is a form specifically designed to address the regulations. Please have your healthcare provider complete and return to me along with the medications.

Your cooperation in this important matter is greatly appreciated. If you have any questions or concerns you may contact me at 993-4000 ext. 2122.

Sincerely,



Tara L. Hayes, RN
Junior/Senior High School Nurse

Fort Plain Junior / Senior High School

Parent and Prescriber's authorization for Administration of Medication in School

A. To be completed by parent or guardian:

I request that my child _____ in grade _____ 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 non-employee, whom I have designated, will administer the medication.

Signature (Parent/Guardian): _____ Date: _____

Address: _____

Telephone (Home): _____ (Work) _____

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 Medications: _____

Prescribed Dosage, Frequency and Route of Administration:_____

Time to be taken during school hours:_____

Duration of treatment: _____

Possible side effects and adverse reaction (if any): _____

Other recommendations: _____

Please check all that apply:

_____ Student is self-directed. (Student is able to identify medication, knows when, how much, and why they take the medication. They know what happens if they don't take it and know when to refuse the medication.)

_____ Student is not self-directed

_____ Student may not carry medication

_____ Student may carry medication and self-medicate at school and sporting events.

Name of licensed prescriber and title (please print): _____

Signature: _____ Date: _____

Phone: _____ Address: _____