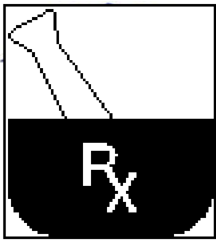

NORTH COLONIE CENTRAL SCHOOL DISTRICT

91 Fiddlers Lane
Latham, NY 12110-5349

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Any medication, **including** non-prescription (over the counter) medications, which are necessary to maintain the student in school, will be administered by the school nurse or designated personnel and may not be administered unless the following requirements are met:

1. **ALL** medications (prescription and non-prescriptions) **must** be prescribed by a licensed prescriber. The school nurse must have a written request from the prescriber that indicated the child's name, drug name, frequency, dosage, date prescribed, and prescribers signature. **THE PHARMACY LABEL DOES NOT CONSTITUTE A WRITTEN ORDER AND CANNOT BE USED IN LIEU OF A WRITTEN ORDER.**
2. A written parental/guardian statement requesting administration of the medication prescribed.
3. The medication needs to be delivered to the school by the parent/guardian in a properly labeled container. Prescription drugs are to be in the prescription container, properly labeled. Non-prescription medications must be in the original container/package with the student's name attached.

These requirements are issued by the State Department of Education and if they are not met........... the student will not receive his/her medication.

A. TO BE COMPLETED BY PARENT OR GUARDIAN:

I request that my child ___________________________________, in grade _______, receive the medications prescribed below by our licensed health care prescriber. I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication. **I understand that I must bring this medication into school initially and with each refill or dosage change.** If there is a dosage change I know I must have the physician write a new prescription accordingly for school.

Signature (Parent/Guardian):____Date:______________________

Address:____

Telephone: Home:__________________________Work:________________________________

B. TO BE COMPLETED BY THE LICENSED HEALTH CARE PROVIDER:

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:_______________________________

STUDENT MAY CARRY OWN MEDICATION: ◯ **Yes, child may carry own meds.**

Possible Side Effects and Adverse Reactions (If Any):____

_______________________________Other Recommendations:____

C. NAME OF LICENSED PRESCRIBER AND TITLE(Please **Print**): _________________________________

Signature of
Prescriber:____Date:______________________

Address:____Phone:_____________________

11/04DJD