



ENLARGED CITY SCHOOL DISTRICT OF MIDDLETOWN

Dear Parent,

When it becomes necessary for a student to take medication during school hours, the nurse will cooperate with the family physician and parent. Medication will be administered by appropriate school personnel as per New York State Education Department guidelines, provided the following conditions are met:

1. The “Authorization for Administering Medication” form is completed. This form can be obtained from the school nurse if needed.
2. Medication is in the original container, labeled with the name of the medicine and dosage, student’s name, physician’s name, amount and time to be given. (Improperly identified medication will not be administered.)
3. Non-prescription medications must have a physician’s written recommendations (same as for prescription drugs).
4. Injectables can only be administered on an emergency basis. The same procedure as outlines above must be followed.

Please Note: All medicines must be brought to the school by the parent or guardian, not by the student. **Students may not carry any medication with them.** Students who are found with controlled or over the counter drugs may be engaging in prohibited conduct of the Student Discipline Code.

All medication, accompanied by the appropriate forms, must be left with the school nurse or administrator by the parent.

Thank you for your cooperation.

Sincerely,
Middletown School District Health Services



ENLARGED CITY SCHOOL DISTRICT OF MIDDLETOWN

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

Authorization for Administration of Medication

A. To be completed by the parent or guardian:

I request that my child _____ grade _____ receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the property labeled original container from the pharmacy. I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication.

Signature (Parent or Guardian): _____

Address: _____

Telephone: Home _____ Work _____ Date: _____

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: _____ DOB: _____

Diagnosis: _____

Name of Medication: _____

Prescribed Dosage, Frequency and Route of Administration: _____

Time to be taken during school hours: _____

Duration of Treatment: _____

Possible Side Effect and Adverse Reactions (if any): _____

Other Recommendations: _____

Name of Licensed Prescriber and Title (please print): _____

Prescriber's:

Signature: _____ Date: _____

Address: _____ Phone: _____