Plattsburgh High School Health Services - Medication Form

New York State Education Law requires a physician's written order for <u>all</u> Over-the- Counter and Prescription Medications

<u>PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES</u>

A. <u>To be completed by the parent or guardian</u>:

I request that my child _____DOB _____receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy.*

Signature (Parent or Guardian):_____
Telephone: Home _____ Work _____ Date_____

B. <u>To be completed by physician</u>:

I request that my patient, as listed below, receive the following medication:

Name of Student _____ DOB _____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment:

Possible Side Effects and Adverse Reactions (if any):

PLEASE CHECK ONE:

☐ I deem this child to be **self directed** and understand that the school nurse or a designated person on a field trip will administer the medication. ***Students are not permitted to self carry or self administer medications at school with the exception of inhalers, insulin and Epi Pens.***

☐ I deem this child to be **non self-directed** and understand that administration of oral, topical, inhalant and injectable medications must remain the responsibility of the school nurse, licensed practical nurse under the direction of a school nurse, physician, or parent.

Physician's Signature_____Date_____
Address: _____Phone:_____

*** Medication must be in original pharmacy labeled container with specific orders and name of medication. OTC (over the counter) medications must be in the original manufacturer's container/package with the student's name affixed to the container. The same applies to drug samples.**

*** Medication and refills must be brought to school by parent, guardian or responsible adult.**