SULLLIVAN WEST CENTRAL SCHOOL DISTRICT HEALTH OFFICE
PO BOX 308 JEFFERSONVILLE, NEW YORK 12748 (845) 482-4610
ELEMENTARY FAX (845-482-4824 HIGH SCHOOL FAX (845)513-2601

MEDICATION POLICY

TO: Parent/Guardian

FROM: Health Office

1. All medication must be registered in the Health Office. **NO** self-Medication is allowed in School (I.E. Over the counter medication, Etc.)
2. The school nurse must have on file a written request from your family physician that includes the following data:
   a. Name of student
   b. Name of medication
   c. Dosage
   d. Frequency of dosage
   e. Possible effects and side effects
   f. Student's physical limitations, if any
3. The school nurse must have on file the parent's written request to administer the medication prescribed by the physician. The request from the physician and parent must be renewed annually.
4. Medication must be delivered to the school by the parent or an adult designated by the parent. Medication must be in the container as dispensed by the pharmacist, giving the name of the child, name of medication, prescription number, method of administration and prescribing physician's name.
5. The administration of medication is basically a school nurse's responsibility. The medication is to be administered in the Health Office by the nurse, when possible or a properly instructed school staff member if the nurse is not available.
6. Parents should be advised to notify the school nurse immediately of any changes of status of a medication or treatment.
7. Unless the above procedures are followed, no child shall be able to take medication, of any kind, in school

Please Note: Unless you indicate otherwise, information contained on this form will be shared on a "Need to Know" basis where the safety and welfare of your child is at stake. Only relevant information will be shared such as emergency contact information, allergies and medical issues that could possible manifest themselves while the student is not in proximity to a nurse. Only teachers and staff that would be in a supervisory capacity over your child would be authorized to access this information.

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PARENT AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

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 provider. The medication is to be furnished by me in the properly labeled, original container from the pharmacy. I understand that the school nurse or other assigned person will administer the medication.

Signature of Parent/Guardian____

Address:____

Telephone: Home___________________Work________________Date________________

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:____DOB________________

Diagnosis____

Name of Medication:____

Prescribed Dosage, Frequency and Route of Administration:___________________________

Times to Be Taken During School Hours:____

Duration of Treatment:____

Possible Side Effects and Adverse Reactions (if any) :_________________________________

Other Recommendations:____

Name of Licensed Provider and Title:____
(Please print)

Provider's Signature____Date______________

Address:____Phone______________

This order will be in effect for the current school year and summer school if needed

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