Lancaster Central School District

117 Central Avenue
Lancaster, NY 14086-1897
(716) 686-3215

Director of Pupil Personnel Services

ADMINISTRATION OF MEDICATION IN SCHOOL

The State of New York mandates that the school nurse follow the procedures listed below:

1. **All medications**, including *non-prescription drugs, given in school,* ***must be prescribed by a licensed medical doctor.***
2. A **written request** from the ***physician*** must be on file. This request must indicate the dosage and frequency of the prescribed drug.
3. A **written request** from the ***parent /guardian*** for the school nurse to administer medication must be on file.
4. The parent / guardian must assume responsibility to have the medication delivered to the Health Office ***in the original container with the proper pharmacy label.***

PLEASE DO NOT SEND ANY TYPE OF MEDICATION TO SCHOOL WITH YOUR CHILD UNLESS THE PROPER PROCEDURE IS FOLLOWED

(Medication Consent forms may be obtained from the School Nurse)

For **field trips**, a separate labeled pharmacy container is necessary to send the medication in. Please obtain a spare bottle from the pharmacy for the school nurse.

Thank you for your cooperation.

Pupil Personnel Services and the Lancaster School Nurses

LANCASTER CENTRAL SCHOOL DISTRICT

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:

Child's Name________________________________ **Grade**__________ **Date of Birth**___________

- I request that my child 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 other designated person in the case of the absence of the school nurse, will administer the medication.

____ ____
Signature (Parent or Guardian) **Please Print Name**

____
Address City State Zip

_________________________ _______________________ _____________________
Telephone No. Work Telephone No. Date

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

- **I request that my patient, as listed above, receive the following medication**:

Medication:_____________________________ Diagnosis:_______________________________________

Dose:___________________ Frequency:______________ Route of Administration:________________
Time:____ Duration of Treatment:________________

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

Other Recommendations: ____
____

____ ____
Name of Licensed Prescriber & Title (please print name) **Prescriber's Signature**

____ ________________
Address City Phone No. Date

NOTE: This section must be signed, in addition to the above District Medication Form, for those students who request permission to carry their own medication on campus or keep this medication in a P. E. locker.

SELF MEDICATION RELEASE FORM

__________________(child's name) has been instructed in the proper use of the following medication procedures:
____
We request that he/she be permitted to carry the medication on his/her person or to keep same in his/her locker or p.e. locker, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use.

____ ______________________________________
Physician's Signature Parent's Signature