

STUDENT MEDICATION PROCEDURES

When your child's physician feels that it is necessary for medication to be taken during the school day, there are certain procedures as mandated by the New York State Education Department which must be followed. School nurses **can not** administer any medication, including over the counter medicines, to students without a written order from a physician. This order must be signed by both the physician and you as the parent/guardian. Our procedures are as follows:

- **EACH SCHOOL YEAR-** At the beginning of each school year, a NEW, completed New Paltz Central School District Authorization for Medication Form must be presented to your child's school nurse. This form must be signed by both the physician and you as the parent/guardian.

- **MEDICATION-**
 - Must be delivered directly to the school nurse by the Parent or Guardian. You will be provided with a receipt for the medication. **NO** medication will be accepted from students.
 - Medication **MUST** be in the original labeled container as prepared by the pharmacist. Over the counter medications must be in the original packaging.
 - At the end of the school year medications must be picked up on the last day of school. Nurses by law are not permitted to keep medications over the summer. Medication can also not be returned to students.

- **STUDENTS AND SELF CARRY MEDICATIONS-** Certain medications may require a student to carry and administer their own medication. This is generally for medications requiring immediate administration such as inhalers or medication for allergic reactions. If it is necessary for your child to carry the medication, the child's physician **must** indicate that your child has been instructed in and understands the proper use of their medication on the New Paltz Central School District Authorization for Medication Form.

- **MEDICAL INFORMATION AND ACADEMICS-** Your child's health plays a part in their academic performance, including behavior and ability to concentrate. In order to help keep your child focused on their academics the nurses are asking permission to share relevant medical information with your child's teachers. To grant this permission please sign the related line on the New Paltz Central School District Authorization for Medication Form.

Incomplete forms will not be accepted

Permission to Administer Multiple Medications

Student Name: _____ DOB: _____
Grade: _____ Teacher/HR: _____ School: _____

To Be Completed By Health Care Provider

Diagnoses _____

Medication Name	Dose	Route	Time	<input checked="" type="checkbox"/> applicable boxes below
				<input type="checkbox"/> AM _____ <input type="checkbox"/> FT <input type="checkbox"/> Self-Directed <input type="checkbox"/> Self Admin-Self Carry
				<input type="checkbox"/> AM _____ <input type="checkbox"/> FT <input type="checkbox"/> Self-Directed <input type="checkbox"/> Self Admin-Self Carry
				<input type="checkbox"/> AM _____ <input type="checkbox"/> FT <input type="checkbox"/> Self-Directed <input type="checkbox"/> Self Admin-Self Carry

Prescriber please use codes below for each medication ordered:

AM	Nurse may administer missed morning dose indicated after verbal or written notification from parent. Please advise parent to send in additional medication
FT	Medication is needed on field trips.
Self-Directed	I assess this student is self-directed regarding their medication. They understand the purpose, name, amount, dose, timing, and effect of taking or not taking the medication, can recognize the medication and refuse to take it inappropriately and can ingest, inhale, apply or calculate and administer the correct dose of the medication independently. NOTE: Must be evaluated/approved by building Nurse.
Self-Administer/ Self-Carry	I have determined this student is consistent and responsible in taking their own medications (Self-Directed) and in addition, give them permission to self- carry and self-administer this medication. They will be considered independent in medication delivery and need intervention only during emergencies. NOTE: Must be evaluated/approved by building Nurse.

Name and Title of Licensed Prescriber (Please Print) _____

Prescriber's Signature _____ **Date** _____ **Phone** _____

To Be Completed By Parent

I give permission for the above medication to be administered to my child as ordered by my health care provider. I will furnish the medication in the original pharmacy container, properly labeled with directions and dosage, or original over-the-counter medication container/packaging with my child's name on it. Please note that this information will be shared with School Personnel involved with your child.

Parent/Guardian Signature _____ **Date** _____ **Phone** _____

Self-Administer/Self Carry

Parent permission and provider consent is required for students to self-administer and self-carry medication. Students with this designation are considered independent in taking their medication at school and **require no supervision by the nurse.** Parents assume responsibility for ensuring that their child is carrying and taking their medication as ordered. Schools may revoke the self-carry/ self-administer privilege if the student proves to be irresponsible or incapable. To request this option please sign below:

Parent/Guardian Signature _____ **Date** _____ **Phone** _____

School Nurse: _____ School _____
Phone: _____ Fax: _____ Email _____