GLENS FALLS CITY SCHOOL DISTRICT
GLENS FALLS, NY

ADMINISTRATION OF MEDICATION / TREATMENT IN SCHOOL

Dear Parent or Guardian:

New York State prohibits the administration of medication / treatment in school unless a written directive is on file in the health office from both the physician and the parent or guardian. This includes oral medication, cough drops, ointment, vitamins and inhalation devices.

In cases where a child must have medication / treatment during school hours, we will require (1) a written doctor's order, (2) written authorization from the parent or guardian, (3) the medication in its original or pharmacy labeled container.

Medications / treatments will be given as close to the prescribed time as possible. Given students schedules and compliance with coming to the Health Office in a timely fashion, medications accepted for school administration may be given up to one hour before and no later than one hour after the prescribed time. Questions about any portion of the procedure should be addressed with the school nurse. Please return this completed form to the health office.

TO BE COMPLETED BY THE HEALTH CARE PROVIDER:

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

Name of Student: _____ Date of birth: _____

Diagnosis: _____ ICD -9 code: _____

Name of medication, dosage, frequency and route of administration: _____

Time to be taken during school hours: _____

Duration of treatment: _____

Possible side effects / adverse reactions: _____

Other medications being taken: _____

_____ _____
date signature of prescriber

_____ _____ _____
phone number name and title of prescriber license number

_____ _____
fax number address

TO BE COMPLETED BY PARENT OF GUARDIAN:

I request that my child, _____, grade _____, receive the medication / treatment as prescribed above by a licensed health care provider. I also give the school nurse and the health provider permission to discuss my child's condition as needed.

The following information and or instructions were discussed with the school nurse: _____

_____

_____ _____
date signature of parent or guardian

_____ _____ _____
home phone work phone cell phone

"Skilled Nursing services will be consistent with the frequency and duration of 1X15minutes daily for the 2013-14 school year.