Authorization to Administer Medication during School and School Activities

The New York State Department of Education, the Board of Education, and the Nurse Practice Act, regulate the administration of medication to children during school hours. Therefore, for your information:

1. All medication must be prescribed by your child’s healthcare provider, including non-prescription medications.

2. Written request of the parent and/or guardian for administration of the medication is required.

3. Prescription medication must be in a container dispensed by your pharmacist, labeled with your child’s name and exact dosage.

4. Parents are requested to bring the medication to school and pick it up when it is no longer required. Students are not allowed to carry medications on the bus.

5. If your child requires medication at home and in school, please request the pharmacist to dispense and label in two containers.

6. Over the counter medications (non prescription including creams and ointments) require a healthcare provider’s order. Parents are required to provide the medication, deliver it to school and sign the permission form.

7. Medication must be picked up at the end of the school year or it will be disposed of by the school nurse. Otherwise it will be disposed of according to New York State guidelines.

8. All medication information is good for the current school year only and must be renewed each school year (this includes over the counter medication).

Please call the nurse in your child’s school if you have any questions regarding these policies.

5.17.2019
WEBUTUCK CENTRAL SCHOOL DISTRICT  
PO Box 405, Amenia, NY  12501

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION

Name of Student: ____________________________  D.O.B./Grade ________/______

Address: ______________________________________  Phone: ____________

__________________________________________________

Grade: _______  Teacher: ______________________

PART 1 – PHYSICIAN’S/HEALTHCARE PROVIDER’S STATEMENT

1. Name/type of medication: ____________________________

2. Diagnosis/Reason: ______________________________________________________

3. Dosage/amount to be given: _____________________________________________

4. Frequency/times to be administered: ________________________________

5. Duration (week, month, indefinite, etc.): _________________________________

6. Anticipated reaction to medication: ________________________________

   (Symptoms, side effects, etc): ____________________________________________

_________________________________________________________________________  

7. If inhaler, Epi Pen or Diabetes medications/devices, may student self-administer: _________

8. If able to self-administer #7, may they carry on their person: _________________

___________________________  _____________________________________________
Health Care Provider’s Signature  Date Signed

Print Name  Address and Phone

PART II – PARENT’S REQUEST/APPROVAL:

I hereby request and give my permission for the above-named school to administer the medication prescribed on this form to my child and if applicable can self-carry and administer per items #7 and #8 above.

___________________________  _____________________________________________
Parent’s Signature  Date Signed

5.17.2019