SAUGERTIES CENTRAL SCHOOL DISTRICT
Call Box A
310 Washington Avenue Ext.
Saugerties, New York 12477
(845) 247-6500 Fax (845) 246-8364
www.saugerties.k12.ny.us

Dear Parent/Guardian:

Children are not permitted to take medication during school hours unless state requirements are met. These requirements have been made to safeguard your child.

In order to give any medication in school, the school nurse must have pg. 2 of this letter fully executed and on file in the health office. Both parent and doctor must complete this form. Information on this form includes:

1. A written order from the physician, indicating the name of the drug, the amount or dosage to be given, and the time it is to be administered.

2. A written note from the parent, giving school personnel permission to give the child the medication as prescribed.

The above requirements include eye drops, eardrops, and over-the-counter medications such as Ibuprofen and Tylenol. The parent is responsible for bringing the medication to the school in the original container.

If you have any questions, please feel free to contact the school.

Sincerely,

Cahill Elementary: Marcy Traudt	845-247-6800 ext.4799	F: 845-681-4001
Morse Elementary: Connie Sciutto	845-247-6960 ext.5799	F: 845-681-4222
Riccardi Elementary: Lynda Angier	845-247-6870 ext.7799	F: 845-246-2582
Saugerties Jr. High: Susan Pavloudakis	845-247-6561 ext.2799	F: 845-246-2773
Saugerties High School: Susan Carter	845-247-6651 ext.1799	F: 845-246-2773

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PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

1. To be completed by the parent/guardian:

I request that my child _____, DOB _____ receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy*.

Parent/Guardian Signature: _____ Date: _____

Contact Phone Number: _____

2. To be completed by the physician:

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

Name of Student: _____ DOB: _____

Diagnosis: _____

Medication	Dosage	Frequency/Time to be taken	Route of Administration

Duration of Treatment:

Possible side effects/adverse reactions (if any):

Physician's Signature _____ Date: _____
Address: _____ Phone: _____

*Medication must be in the original pharmacy labeled container with specific orders and name of medication. Medication refills must be brought to school by parent/guardian or their designee.