School #4

Be brave • Be kind • Work hard

South Oceanside Road School #4
3210 Oceanside Road
Oceanside, NY 11572

Phyllis Harrington, Ed.D
Superintendent of Schools
Ph: 516-678-1215 Fax: 516-678-7503

Jaclyn Graham
Principal
Ph: 516-678-7581 Fax: 516-678-8590

School Medication Administration Instructions

School 4 Family:

In order to keep and give any medications in school (including those that are over the counter) the nurse's office must have a doctor's order on file for each medication per New York State law.

If you wish for the nurse to administer any medications to your child(ren) please fill out, and have your child's prescriber fill out the attached form. There must be a separate form completed for each child that you wish for medication to be administered to. This form must be completed annually, and be signed and stamped by the prescriber's office.

Once the form is completed, you can email it to tgonzalez@oceansideschools.org, have it faxed to : (516) 678-8590, or send it in with your child.

Please note that the parent/guardian must provide the medication as we do not keep stock medications in the health office. The medication(s) must be non-expired and in the original pharmacy labeled container/packaging, and will stay locked in the nurse's office for the duration of the school year or until the end of the doctor's order. Medications cannot travel back and forth between school and home daily, weekly, etc.

If you have any further questions or concerns, our nurse's office can be reached in any of the ways below.

Thank you for your cooperation and understanding.

Sincerely,

Tori Gonzalez, RN
School Nurse
S. Oceanside Rd. School #4
(T) (516) 678-7574/(F) (516) 678-8590
(E): tgonzalez@oceansideschools.org

Oceanside School District
Parent and Prescriber's Authorization for
Administration of Medication in School

A. To be completed by the parent or guardian:

I request that my child, _____, in grade _____, 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.

I hereby release the school personnel, the Board of Education, and the District of any and all liability arising out of the decision to administer medication, the administration of such medication, and/or any reaction to the medication which may occur to the above-named student.

Signature of Parent or Guardian _____

Address _____

Telephone: Home _____ Work _____ Cell _____

Date _____

B. To be completed by the licensed health care prescriber:

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

Name of Student _____ Date of Birth _____

Diagnosis _____

Name of Medication _____

Prescribed dosage, frequency, and route of administration _____

_____

Time to be taken during school hours _____

Duration of treatment _____

Possible side effects and adverse reactions (if any) _____

_____

Other recommendations _____

_____

Name of Licensed Prescriber and Title (please print) _____

_____

Prescriber's Signature _____ Date _____

Address _____ Phone _____