

Hyde Park Central School District

P.O. Box 2033

Hyde Park, New York 12538-8033

The New York State Department of Education, the Hyde Park 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 permission from your healthcare provider. 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.
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.

HYDE PARK CENTRAL SCHOOL DISTRICT
P.O. Box 2033
HYDE PARK, NEW YORK
School Year _____

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION

Name of Student: _____ D.O.B. _____

Address: _____ Phone: _____

Grade: _____ Teacher: _____

PART 1 – PHYSICIAN’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 or EpiPen 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.

Parent’s Signature

Date Signed

06/02/2009