Pine Plains Central School District
2829 Church Street
Pine Plains, NY 12567

Cold Spring Early Learning Center
358 Homan Road
Stanfordville, NY 12581
School Nurse, J. Heath, RN
j.heath@ppcsd.org
(845) 868-7451 ext. 2239; (845) 868-1105 (f)

Seymour Smith Intermediate Learning Center
41 Academy Street
Pine Plains, NY 12567
School Nurse, J. Funk, RN
j.funk@ppcsd.org
(518) 398-3000 ext. 3103; (518) 398-1141 (f)

Stissing Mountain Jr./Sr. High School
2829 Church Street
Pine Plains, NY 12567
School Nurse, M. Anderson, RN
m.anderson@ppcsd.org
School Nurse, J. Zengen, RN
j.zengen@ppcsd.org
(518) 398-7181 ext. 1335; (518) 398-0169 (f)

RE: Prescription Medication Form

PART 1 (to be completed by physician):

Student's Name: ____ DOB: ______________________________

Diagnosis: _______________________________________Duration of Treatment: ____________________________

MEDICATION	DOSAGE	ROUTE OF ADMINISTRATION	FREQUENCY

Possible Side Effects: ____

PLEASE CHECK ONE:

- ☐ I deem this child **NURSE DEPENDENT** and state that administration of oral, topical, inhalant and injectable medications must remain the responsibility of the school nurse, physician or parent.
- ☐ I deem this child **SUPERVISED:** in the absence of the school nurse, another designated adult may assist child.
- ☐ I deem this child **INDEPENDENT:** student has been instructed in the proper use of the above listed medication(s) and is permitted to self-carry and self-administer**.** It is my professional opinion that this student is responsible**.**

Physician Signature: ____ Date: ___________________

PART 2 (to be completed by parent or guardian):

I request that my child _______________________receive the medication as prescribed above by our physician. If my child is **INDEPENDENT,** I request that he/she be permitted to carry the above prescribed medication(s) on his/her person or to keep the above prescribed medication(s) in his/her locker and **SELF-MEDICATE**, as I consider him/her responsible. My child has been instructed in and understands the purpose, appropriate method, frequency and use of his/her medication. My child understands that he/she is responsible and accountable for carrying and using his/her medication. It is understood that if there is irresponsible behavior or a safety risk, *the privilege* of carrying his/her medication will be rescinded. If my child is **SUPERVISED**: I will allow another designated individual to assist my child with medication administration in the absence of the school nurse.

Parent or Guardian Signature: _______________________________________ Date: _____________________

MEDICATION MUST BE DELIVERED TO SCHOOL BY AN ADULT IN AN ORIGINAL PHARMACY LABELED CONTAINER.