# GREAT NECK PUBLIC SCHOOLS
## Health Services
## *N.Y.S. Guidelines for the Administration of Medication*

The Great Neck School District, in accordance with the New York State Education Department, will administer medication to students while in school only when the following rules are followed:

1. **A WRITTEN ORDER FROM A LICENSED PRESCRIBER IS REQUIRED**
   All medications, including nonprescription drugs, given in school shall be prescribed by a licensed prescriber on an individual basis as determined by the child's health status.

   A. Written order for prescription and nonprescription medications should minimally include:
      a. Student's name and date of birth
      b. Diagnosis
      c. Name of medication
      d. Dosage and route of administration
      e. Self-administration orders – if indicated
      f. Frequency and time of administration
      g. For PRN (as necessary) medications → conditions under which medication should be administered
      h. Date written
      i. Prescriber's name, title and signature
      j. Prescriber's phone number

   B. Special considerations
      a. Medication orders must be renewed annually or when there is a change in medication or dosage.
      b. The pharmacy label does not constitute a written order and cannot be used in lieu of a written order from a licensed prescriber.

2. **A WRITTEN STATEMENT FROM THE PARENT OR GUARDIAN REQUESTING ADMINISTRATION OF THE MEDICATION IN SCHOOL AS ORDERED BY THE LICENSED PRESCRIBER IS REQUIRED.**

3. **MEDICATION**

   A. PRESCRIPTION MEDICATIONS → The pharmacy label must display:
      a. Student's name
      b. Name and phone number of pharmacy
      c. Licensed prescriber's name
      d. Date and number of refills
      e. Name of medication/dosage
      f. Frequency of administration
      g. Route of administration and/or other directions

   B. OTC MEDICATIONS → Must be in the original manufacturer's container/package with the student's name affixed to the container. The same applies to drug samples.

*** The parent or guardian must assume responsibility to have the medication delivered directly to the health office in a properly labeled original container.**

** Medications should not be transported daily to and from school. Parents should be advised to ask the pharmacist for two containers – one to remain at home and one at school.

*** NYS Education Department regulations require unused portions of medication be returned to parent or designated person only

**GREAT NECK PUBLIC SCHOOLS**
**Health Services**
***Physician's Order / Parent Authorization for Administration of Medication***

SCHOOL _____

DATE _____

GRADE _____

## PHYSICIAN'S ORDER

TO BE COMPLETED BY PHYSICIAN:

PLEASE ADMINISTER TO MY PATIENT: _____

THE FOLLOWING MEDICATION AS INDICATED:

MEDICATION _____

DOSAGE _____

TIME _____

SIDE EFFECTS, IF ANY _____

_____
Physician's Signature & Stamp

_____
Date

## PARENT AUTHORIZATION

TO BE COMPLETED BY THE PARENT OR GUARDIAN:

I request that my child, _____, grade_____, receive the medication (Prescription or Over the Counter) prescribed 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 assigned person will administer the medication.

_____
Parent or Guardian Signature

_____
Date

# Great Neck Public Schools

Health Services

## PROVIDER AND PARENT PERMISSIONS
## REQUIRED FOR INDEPENDENT MEDICATION USE AND CARRY

**Directions for the Health Care Provider:** This form may be used as an addendum to a medication order which does not contain the required diagnosis and attestation for a student to independently use and carry their medication as required by NYS law. A **provider order** and **parent/guardian permission** is needed in order for a student to carry and use medications that require rapid administration to prevent negative health outcomes. These medications should be identified by checking the appropriate boxes below.

**Student Name:** _____ **DOB:** _____

**Health Care Provider Permission for Independent Use and Carry**

I attest that this student has demonstrated to me that they can self-administer the medication(s) listed below safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school/school sponsored activity with no supervision by school staff. This order applies to the medications checked below:

This student is diagnosed with:

- ❑ Allergy and requires Epinephrine Auto-injector
- ❑ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication
- ❑ Diabetes and requires Insulin/Glucagon/Diabetes Supplies
- ❑ _____ (State Diagnosis) which requires rapid administration of _____ (Medication Name)

Signature: _____ Date: _____

**Parent/Guardian Permission for Independent Use and Carry**

I agree that my child can use their medication effectively and may use and carry this medication independently at any school/school sponsored activity with no supervision by school staff.

Signature: _____ Date: _____

**Please return to School Nurse:**

| School Nurse: | | School: |
|---|---|---|
| Phone #: | Fax: | Email: |