CHESTER UNION FREE SCHOOL DISTRICT

Chester Elementary School
Mrs. Mary Mulvihill
2 Herbert Drive
Chester, NY 10918
469-2178 x2209
Fax: 469-2794

Chester Academy
Mrs. Gina Straub
64 Hambletonian Ave
Chester, NY 10918
469-2231 x3315
Fax: 469-6634

INSTRUCTIONS FOR IN-SCHOOL MEDICATIONS

It is required that ALL medications, including aspirin, Tylenol, nose drops, and of course prescription drugs be **BROUGHT TO SCHOOL by a PARENT or other ADULT.** They are to be in their **ORIGINAL PHARMACY CONTAINER.** You may need to ask the pharmacist for two labeled containers for prescription drugs, one for home and one for school.

The medication **MUST BE ACCOMPANIED BY A PARENT NOTE** AND a **SIGNED PHYSICIAN'S ORDER STATING** medication, dose, time, how long, and reason for taking.

The NEW YORK STATE REGULATIONS concerning medication dispensing in school are very specific.

Thank you for your understanding and cooperation. If you should have any further questions, please do not hesitate to contact the Health office.

CHESTER ACADMEY SCHOOL HEALTH OFFICE –	**PHONE#**	**(845) 469-2231, EXT. 3315**
	FAX#	**(845) 469-6634**
CHESTER ELEMENTARY SCHOOL HEALTH OFFICE	**PHONE#**	**(845) 469-2178, EXT.2209**
	FAX#	**(845 469-2794**

CHESTER UNION FREE SCHOOL DISTRICT
HEALTH OFFICE

Elementary School
2 Herbert Drive Ave
Chester, NY 10918
845-469-2178 x2209
Fax: 845-469-2170

Chester Academy
64 Hambletonian Avenue
Chester, NY 10918
845-469-2231 x3315
Fax: 845-469-6634

PARENT AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

A. To be completed by the parent/guardian:

I request that my child _____ grade _____
Receive the medication as prescribed below by our licensed health care provider. 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 case of the absence of the school nurse, will administer the medication.

Signature (Parent/Guardian): _____

Address: _____

Telephone: Home _____ Work _____ 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: _____

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): _____

Signature: _____ Date: _____

Address: _____ Phone: _____

Self-Medication Release (ACADEMY ONLY):

My student, _____, has been instructed in the proper use of the following emergency medication procedures: _____
We (Physician's signature) _____ and
(Parent/Guardian's signature) _____
request that my student be permitted to carry the emergency medication on his/her person or to keep same in his/her locker or P.E. locker, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency or use.

Chester Academy

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

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 carry and use their medication as required by NYS law. A **provider order** and **parent/guardian permission** are 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 he or she 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. Staff intervention and support is needed only during an emergency. 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
- ☐ _____ which requires rapid administration of _____
  (State Diagnosis) (Medication Name)

Signature: _____ Date: _____

Parent/Guardian Permission for Independent Use and Carry

I agree that my child can use their medication effectively and may carry and use this medication independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency.

Signature: _____ Date: _____

Please return to School Nurse:

School Nurse:		School:
Phone #:	Fax:	Email: