



Dear Parent/ Guardian,

If your child has a history of asthma or respiratory disorders and uses an inhaler, or any other medical history that requires them to take **prescription or over the counter medications** during school hours, the Board of Health requires you to fill out the following paper work. This allows your child to carry their medications/ inhalers in school. It is extremely **IMPORTANT** for them to carry their inhalers at all times, especially during gym and sports participation so they can use them when needed. No child will be able to receive medications or carry them in school without this form. This includes all over the counter medications such as Tylenol or Ibuprofen for headaches or minor aches and pains. Please have this form filled out and signed by your **PHYSICIAN with the name of the medication, dosage & route, frequency and time, or prn (as necessary) indicating the condition which the medication should be given and return to school with your physical no later than the first day of school. A new form is required each new school year.** You are also responsible to send in any medications other than Tylenol or Ibuprofen with your child to be locked in the nurse's office. With doctor and parental permission asthmatics may carry their inhalers and allergic students may carry their EpiPens. Any questions please feel free to contact me at (718) 441-2100 ext. 123.

Thank you for your cooperation.

Mrs. Maria Gallagher RN
School Nurse

Nurses Office

83-53 Manton Street, Briarwood, NY 11435 | Phone: 718-441-2100 ext. 123 | www.molloyhs.org

Recognized as an Exemplary High School by the Federal Department of Education
Recognized as an Outstanding American High School by U.S. News & World Report



SELF-MEDICATION RELEASE FORM

Date: _____

/ _____ has been instructed in the proper use of the
following medication procedures / _____

We / _____ and / _____
Physician's Signature **Parent/Guardian Signature**

request that / _____ be permitted to carry the medication
on his/her person or to keep same in his/her locker or PE locker as we consider
him/her responsible. He/she has been instructed in and understands the purpose
and appropriate method and frequency of use.

Physician's Stamp



**PARENT & PHYSICIANS AUTHORIZATION
FOR ADMINISTRATION OF MEDICATION IN SCHOOL**

A. TO BE COMPLETED BY THE PARENT OR GUARDIAN:

I request that my child X _____ Id# _____ 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 another designated person in the case of the absence of the school nurse, will administer the medication.

Signature of Parent/Guardian X _____ Date: _____

*

B. TO BE COMPLETED BY THE LICENSED HEALTH CARE PROVIDER:

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

Name of Student _____ Id# _____

Diagnosis _____

Name of Medication _____

Prescribed Dosage: _____

Time to be taken during school hours _____

Duration of treatment _____

Possible side effects (if any) _____

Name of Licensed Prescriber _____

Prescriber's Signature X _____

Address _____ Telephone # _____

Physician's Stamp