

**MOUNT VERNON CITY SCHOOL DISTRICT
HEALTH SERVICES
MOUNT VERNON, NEW YORK**

**GUIDELINES WHEN INTERNAL MEDICATION IS NECESSARY
DURING SCHOOL HOURS**

Occasionally, it becomes necessary for the health and well being of a child that an internal medication be taken by the child during regular school hours of the day. Medications may not be carried to school in an envelope or pocket and then be taken by the child, or, as is sometimes requested, be given to the child by school personnel. When it is necessary for a child to have medication during school hours, the following procedure must be followed:

1. Bring to the school nurse a completed **Authorization of Medication Form Part A** to be completely filled out by parent. **Part B** to be completely filled out by a licensed Health Care Provider and signed.
2. **Self Medication Release Form** to be completed in addition to the Authorization for Administration of Medication in School, if child is to carry medication and self medicate.
3. Parent or guardian must bring the medication, in the original container, directly to the school nurse.
4. The school nurse will then consult with the Medical Director for his/her approval that the medication can be given in school. If approved, the medication will be given by school personnel as directed by the family physician.
5. If there is any change in the medication or dosage, the above procedure must be repeated.

If any of this information is missing, medication will not be administered.

**STRICT ADHERENCE TO THE ABOVE PROCEDURE MUST BE MAINTAINED
FOR THE PROTECTION OF ALL PUPILS.**

**MOUNT[®] VERNON CITY SCHOOL DISTRICT
HEALTH SERVICES**

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

Authorization for Administration of Medication

A. To be completed by the parent or guardian:

I request that my child _____ grade _____
Receive the medication as prescribed below by our licensed health provider. The medication is to
be furnished by me in the properly labeled container from the pharmacy. I understand that the
school nurse or other assigned person will administer the medication.

Signature (Parent or Guardian) _____

Address _____

Telephone: Home _____ Work _____ 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 _____ Date of Birth _____

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) _____

Prescriber's Signature _____ Date _____

Address _____ Phone _____

(over)

**MOUNT VERNON CITY SCHOOL DISTRICT
HEALTH SERVICES**

SELF-MEDICATION RELEASE FORM

Date _____

Child's Name _____

Has been instructed in the proper use of the following medication procedures:

We (Physician's Signature) _____

And (Parent or Guardian's Signature) _____

Request that (Child's name) _____ be permitted to carry the medication on his/her person or to keep some 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 of use.

Note: This form must be completed in addition to routine district medication form for those students who request permission to carry their own medication on campus or keep this medication in a P.E. locker.