GUILDERLAND CENTRAL SCHOOL DISTRICT
SCHOOL HEALTH SERVICES

Dispensing of Medication to Students in the School Setting

******MEDICATION ORDERS MUST BE RENEWED AT THE BEGINNING OF EACH SCHOOL YEAR******

In order for the school nurse, as directed by the NYS Education Department, to dispense medication to your child during school hours, school sponsored activities and field trips, all of the following requirements must be met:

1. **An ORIGINAL SIGNED ORDER** from the prescribing physician **for all prescription and non-prescription medications.** The order should include:
   - Reason for prescribing the medication; and
   - Adverse reactions that need to be observed and reported.
2. **All prescription medications** must be in their original pharmacy containers, properly labeled with the following information: **Student's Name, Name of Medication, Dose/Time, and Prescribing Doctor.** Ask the pharmacist to dispense medication into two containers – one for school and one for home.
3. **All non-prescription medications (over the counter)** must be in its original, unopened manufacturer's container with the student's name affixed to the container.
4. **A signed note from the parent** giving the school nurse permission to dispense the medication as prescribed by the doctor, or **parent signature at bottom of this sheet.**
5. **All medication must be delivered to the school nurse by an adult**, preferably the parent.
6. Students are **NOT** allowed to have medications on the bus, in their locker or on their person with the **exception of asthma inhalers and Epi-pens that may be self-carried.** A doctor's written order, as well as parent permission must be on file in the nurse's office and the approval of the school nurse must be given for a student to self-carry. In addition, students must demonstrate they can be self-directed, meaning can self medicate.
   a. A separate medication form may be obtained by calling the Health Office, for your physician to complete once he/she determines that the student can self administer and self carry.

Student Name_____ **DOB**_____ **Grade** _____

Medication_____**Dosage**_____**Time**_____

Reason for Medication_____

Possible Side Effects _____

Physician's Signature_____ **Date**_____

Physicians Stamp_____

I, being the parent/guardian of the above student give the school nurse permission to discuss with the doctor this medication order and administer the above medication to my child.

Parent/Guardian Signature_____ **Date** _____

If you have any questions or concerns, please contact the Nurse's Office