SAINT AGNES
S C H O O L

Dear Parents,

The State of New York is quite clear as to the school's role in giving medicine to children.

1. Only those medications which are necessary to maintain the student in school and which must be given during school hours should be administered.
2. Any prescribed medication needed by non self-directed students must be given by school nursing personnel.
3. Unlicensed persons in the school, following assignment and in conjunction with the approval by school nursing personnel may assist self-directed students.

ALL medication must be brought to and from school by an adult; children are NOT allowed to carry medicine to/from school.

ALL medication, including non-prescription drugs, given in school shall be prescribed by a licensed prescriber on an individual basis.

The written order for prescriptions and non-prescription medications should include information on this form. When a medication comes to the health office without this written order from a licensed prescriber, we will not administer the medicine. A pharmacy label does not constitute a written order. All students requiring medication during school hours should receive their medication in the Health Office, except where students are allowed to carry their own for self-administration. Many doctors will help you by faxing this form to us at the Elementary School (518) 523-4314.

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

This form is required annually for all students.

To be completed by the parent –

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.

Signature_____

To be completed by the Health Care Prescriber –

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

Name of student: _____

Diagnosis: _____

Name of medication: _____

Prescribed dosage, frequency, and route of administration: _____

Time to be taken during school hours: _____

Duration of treatment: _____

Name and title of licensed prescriber *(please print)*: _____

Signature: _____ Date: _____