Gowanda Central School District

PROCEDURE FOR MEDICATION TAKEN IN SCHOOL

Form must be signed by a Doctor, Nurse Practitioner or Physician's Assistant

No medication may be given to a student during school hours without following the procedure outlined by the New York State Education Department. Following is the Gowanda Central School District Policy for administering medication:

1. A **Written Order** from the prescribing provider is required stating:
    a. Students name
    b. Diagnosis
    c. Name of Medication
    d. Dosage and route of administration
    e. Frequency and time of administration
    f. Date written
    g. For PRN (as necessary) medications-conditions under which medication should be administered
2. Over the counter medications require the **SAME** procedures as prescription medications. Over the counter medications must be in the original manufacturer's container with the student's name affixed to the container. (Ex: Tylenol, Advil, cough medicine)
3. A written request from the parent to administer the prescribed medication.
4. The parent must deliver the medication to the nurse and not send it with the student. **Do not** send pills or medication of any kind with your daughter/son because they will **not** be administered. These procedures must be followed for the safety of the students.
5. ***If your child's medical provider has deemed him/her competent to carry and self-administer their rescue medications please have the provider complete and submit the "Independent Medication Use and Carry" form.***

(A New Order and Medication re-fill are needed each year)

Katie Pawlak RN--HS Nurse	Kathy A. Poland RN--MS Nurse	Rhonda Thropp RN-ES Nurse
FAX 995-2125	FAX 995-2184	FAX 241-3119
Phone 995-2104	Phone 995-2124	Phone 532-3325 EXT 4003

PARENT/GUARDIAN PERMISSION

Name of Student _____ Grade _____ DOB _____

I hereby give my permission for the School Nurse to administer medication during the school day to my child.

Date _____ Signature of Parent/Guardian _____

PHYSICIAN'S INSTRUCTIONS FOR MEDICATION ADMINISTRATION IN SCHOOL

Student's Name _____ DOB _____

Medication _____ Route _____

Dosage _____ Frequency and Time _____

Reason for Administration _____

Special Instructions _____

Health Care Provider Signature and Stamp_____

DATE _____ PHONE _____

RETURN THIS FORM TO YOUR CHILD'S BUILDING NURSE