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)

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 _____

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 _____

RETURN THIS FORM TO YOUR CHILD'S BUILDING NURSE

Rachel Ruff RN--HS Nurse	Bailey Bond RN--MS Nurse	Michelle Gilson, RN-ES Nurse
FAX 995-2125	FAX 995-2184	FAX 241-3119
Phone 995-2104	Phone 995-2124	Phone 532-3325 EXT 4003

PROVIDER AND PARENT PERMISSIONS
REQUIRED FOR INDEPENDENT MEDICATION USE AND CARRY

Directions for the Health Care Provider: This form may be used as an addendum to a medication order which does not contain the required diagnosis and attestation for a student to independently use and carry their medication as required by NYS law. A **provider order** and **parent/guardian permission** is needed in order for a student to carry and use medications that require rapid administration to prevent negative health outcomes. These medications should be identified by checking the appropriate boxes below.

Student Name: _____ **DOB:** _____

Health Care Provider Permission for Independent Use and Carry
I attest that this student has demonstrated to me that they can self-administer the medication(s) listed below safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school/school sponsored activity with no supervision by school staff. This order applies to the medications checked below:
This student is diagnosed with:

- ❑ Allergy and requires Epinephrine Auto-injector
- ❑ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication
- ❑ Diabetes and requires Insulin/Glucagon/Diabetes Supplies
- ❑ _____ (state diagnosis) which requires rapid administration of _____ (state medication)

Health Care Provider Signature: _____ Date:_____

Parent/Guardian Permission for Independent Use and Carry
I agree that my child can use their medication effectively and may use and carry this medication independently at any school/school sponsored activity with no supervision by school staff.
Signature: _____ Date: _____

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