

Poly Prep Lower School
50 Prospect Park West
Brooklyn, NY 11215
718-768-1103 Fax 718-768-1687

ADMINISTRATION OF MEDICATION IN SCHOOL

All medications, even over the counter medications, need to be ordered by a licensed health care provider. Parts A and B need to be completed, stamped and signed.

- All medications must be sent to school in the original, prescription bottle clearly marked with child's name, name of medication, dosage to be given, expiration date and the period of time to be administered. Medication must be dropped off in the school office by an adult. *Medication should never be sent to school in child's lunchbox.*
- If student will self medicate (such as use an inhaler), Section II must also be completed.
- The school does not dispense over-the-counter medications including Tylenol, Benadryl, cough syrups, etc., without a completed Administration of Medication in School form.

A. To be completed by the licensed health care provider:

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

Child's Name: _____ Date of Birth: _____

Diagnosis: _____

Name of Medication: _____

Dosage, Frequency and Route of Administration: _____

Time to be Taken During School Hours: _____

Duration of Treatment: _____

Specific Instructions for Meds: _____

Side Effects and Adverse Reactions: _____

Action to be Taken if Side Effect Occurs: _____

Name of Licensed Prescriber and Title: _____

Prescriber's Signature: _____ Date: _____

Address: _____ Phone: _____

Stamp required

B. To be completed by the Parent or Guardian:

I request that my child _____ class _____ receive the medication as prescribed by our licensed health care provider. I understand that the school nurse will administer the medication or a designee will supervise my child taking his/her own medication.

Parent's Name _____

Parent's Signature _____ Date _____

SECTION II Student Self-Administration Authorization

A. Physician/Health Care Provider Authorization

The above named student is under my medical supervision. This student understands how and when to use the medication that s/he takes via inhaler or by mouth. **S/he should be allowed to carry and use her/his inhaler or medication.**

Physician's Name _____

Physician's Signature _____ Date _____

Please complete this section if your child will carry and self-administer medication:

B. Child's Name _____ has been instructed in the proper administration of this medication. I request that my child be permitted to carry the medication on his/her person and/or to keep in his/her locker. My child has been instructed in and understands the purpose and appropriate method and frequency of use of this medication.

Parent's Name _____

Parent's Signature _____ Date _____

Complete this form and return it to the School Nurse. It must be on file before any medication can be administered. Fax #: (718) 768-1687