EASTCHESTER UNION FREE SCHOOL DISTRICT

580 White Plains Road
Eastchester, NY 10709

Health Office
(914) 793-6130

Dear Parent/Guardian:

If you anticipate that your child needs to take medication during the upcoming school year, either prescription or non-prescription, you must have your doctor complete the attached *Medication Consent Form*. Once this form is complete, return the form and the **medication in its original container.** If medications are not properly labeled and I do not have a signed physician and parent consent form, the medication cannot be administered.

Please be aware that new guidelines support the need for a student to possibly carry **certain allergy medications (Epi-Pen, Inhaler, Benadryl) with him/her at all times**. If this is the case for your child, please have his/her physician complete the attached *Self-Medication Release Fo*rm as well.

Please remember to stop by the Health Office at the end of the school year to pick up any medications that you have left with me.

If you have any questions, please call my office.

Sincerely,

School Nurse

CA/soc

FILENAME: MEDICATION CONSENT LETTER (Rev. 5/11)

PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

a. To be completed by the parent or guardian:

I request that my child _____, DOB_____ receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy*****.

PLEASE CHECK ONE:

☐ I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication, including field trips, to my **self directed child.** ***(Please have your physician fill out Self-Medication Release Form on reverse side of this form.)***

☐ I understand that administration of oral, topical or inhalant medications to my **non self-directed child** and injectable medications must remain the responsibility of the school nurse, licensed practical nurse under the direction of a school nurse, physician or parent.

Signature (Parent or Guardian):_____Date:_____

Telephone: Home_____ Work _____ Cell_____

b. To be completed by physician:

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

Name of Student_____ DOB_____

Diagnosis:_____

_____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment: _____

Possible Side Effects and Adverse Reactions (if any):_____

_____

Physician's Name/Address:_____ Telephone:_____

Physician's Signature:_____ Date: _____

*****Medication must be in original pharmacy labeled container with specific orders and name of medication.
*****Medication and refills must be brought to school by parent/guardian or responsible adult.

(**SEE NEXT PAGE)**

SELF-MEDICATION RELEASE FORM

Date: _____

Child's Name: _____

has been instructed in the proper use of the following medication procedures:

_____

_____

We, (Physician's name/stamp and signature)_____

_____

And (Parent or Guardian's name and signature)_____,

_____

request that (Child's name)_____ be permitted to carry the medication (Epi-Pen, Inhaler, Benadryl) on his/her person or to keep same in his/her locker or P.E. locker, as we consider him/her responsible. He/she has been instructed in and understands the appropriate method and frequency of use.

NOTE: This form must be completed *in addition* to routine district medication form for those students who request permission to carry their own medication on campus or keep this medication in a P.E. locker.

We recommend that a second inhaler be kept in the Health Office in case of inaccessibility to child's inhaler.