Long Island School for the Gifted
Parent Medication Information

Guidelines Regarding Medication in School:

New York State Law requires that every medication (prescription and over-the-counter) dispensed by the school nurse during school hours, must be accompanied by an Administration of Medication Form (available from the school nurse), signed by the parent and the doctor. A written note indicating parent consent AND a dated doctor's order are also acceptable. No medication will be given out without this documentation.

Prescription medication must be in the original bottle issued by the pharmacist with the child's name, dosage, frequency and duration. Over-the-counter medications must be in the original, sealed manufacturer's package with the student's name clearly labeled.

The parent or guardian must assume responsibility for notifying the nurse of any changes in medication or dosage. All medication must be delivered to the nurse and be picked up by an adult at the end of the school year. Medication must be renewed annually.

Students are expressly prohibited from carrying medication and self-administering any medication, including over-the-counter medications. There is a Self-Medication Release form available in the nurse's office. This form can be used for asthma inhalers and Epi Pens if both the parent and doctor agree that your child can carry and self-administer the medication. **Cough drops are not permitted as they are a choking hazard.**

LONG ISLAND SCHOOL FOR THE GIFTED

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Carol Yilmaz, Founder
Patricia Geyer, Ed.D., Head of School

A. To be completed by parent or guardian:

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. I understand that the school nurse, or other assigned person will administer the medication.

Signature (parent or guardian) _____

Address: _____

Telephone: (Home) _____ (Work) _____ Date: _____

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

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

Name of Student: _____ Date of Birth: _____

Diagnosis: _____

Name of Medication: _____

Prescribed Dosage, Frequency and Route of Administration:

_____

Time to be Taken During School Hours: _____ Duration of Treatment: _____

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

_____

Other Recommendations: _____

Name of Licensed Prescriber & Title (please print): _____

Prescriber's Signature: _____ Date: _____

Address: _____ Phone: _____

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