Herricks Union Free School District
999-B Herricks Road
New Hyde Park, NY 11040

PROCEDURE FOR THE ADMINISTRATION OF MEDICATION AND MEDICAL MONITORING IN SCHOOL

Dear Parent or Guardian,
In compliance with New York State Education Law the following procedures must be followed for the administration of any prescription and non-prescription medications. The purpose of this procedure is to protect and prevent your child from the possible hazards of sharing medications with the other students, losing medications and not receiving the medications as prescribed.

PROCEDURE

1. The school nurse must have on file a signed consent from the parent or guardian and licensed prescriber. The consent must be completed each school year.

2. All medications should be delivered directly to the school nurse by the parent/guardian.

3. Prescription medications must be delivered in the original prescription container
   a. Student name
   b. Name and phone number of pharmacy
   c. Licensed prescriber's name
   d. Date and number of refills
   e. Name of medication and dosage
   f. Frequency of administration
   g. Route of administration and/or other directions

4. Non-prescription medications must be in the original manufacturer's container with the student's name affixed to the container.

5. To carry and self administer medication, the school nurse must receive a request from a parent/guardian and the licensed prescriber permitting the student to self administer medication.

6. For children who require additional medical monitoring or treatment, the school nurse must receive a written order from a licensed prescriber including the type of monitoring/treatment, the frequency of monitoring/treatment, the specific parameters of monitoring/treatment.

7. The parent/guardian must provide the properly labeled monitoring/treatment supplies, and provide the proper maintenance and up keep of the equipment and ensure its good working order.
8. The parent/guardian must inform the school nurse of any change in the child's medical condition.

Self-directed Child: An individual who is capable and competent to understand a personal care procedure, can correctly administer it to him/herself each time it is required, has the ability to make choices about the activity, understands the impact of those choices, and assumes responsibility for the results of those choices.

Whether a student should be considered self-directed should be based on the student's cognitive and/or emotional development rather than age or grade. Factors such as age of reason and mental/emotional disability are additional considerations in determining a student's ability to be self-directed. Usually a student may be considered to be self-directed if he/she is consistently able to do all of the following:

- Identify the correct medication (e.g., color, shape)
- Identify the purpose of the medication (e.g., to improve attention)
- Determine the correct dosage is being administered (e.g., one pill)
- Identify the time the medication is needed during the school day (e.g., after lunch)
- Describe what will happen if the medication is not taken (e.g., unable to complete school work)
- Refuse to take medication if student has any concerns about its appropriateness.

IHP Discussed with
Parent/Guardian
Date: _______ **Initials:** ____

Herricks Union Free School District
999-B Herricks Road
New Hyde Park, NY 11040

PARENT & PHYSICIAN AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

Name (last, first) ______________________________ **DOB**__________
Address ______________________________ **Phone** ______________

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 in the properly labeled original container from the pharmacy.

Check the appropriate line: School Year: Sept ____ - June ____

_____ I understand that the administration of oral, topical, inhalant, injectable medications to my **Non self-directed child** must remain the responsibility of the school nurse, physician, or a parent.

_____ I understand that the school nurse, or other designated person in the case of absence of the school nurse, will supervise and assist in administering the medication, including field trips to my **self directed child* (see back of form).**

_____ My child is permitted to **self carry and self administer** the medication.**(MS & HS only)**

I acknowledge my obligation to inform the school nurse of any change in my child's medical condition.

Signature: ______________________________ Date: ____________

B. TO BE COMPLETED BY AND SIGNED BY PHYSICAN

Name of student: ______________________________ DOB: ____________

Diagnosis: ______________________________

Medication	Dosage	Frequency/Time To Be Taken	Route of Administration

Duration of treatment: ______________________________

Common Side Effects/Adverse Reactions (if any): ______________________________

Circle all that apply: Child requires assistance/supervision

Child may self carry/ self administer

______________________ ______________________ ________ ______________
Physician's name (print) Physician's signature Date Stamp