

KEENE CENTRAL SCHOOL

33 Market St., P.O. Box 67, Keene Valley, NY 12943 (518) 576-4555 Fax (518) 576-4599 www.keenecentralschool.org

ADMINISTRATION

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Dear Parent/Guardian:

Due to very strict state regulations, we must enforce tighter controls on medication in our schools. The State Department of Education requires that no medication shall be given in school without a physician's written order.

In order for the school nurse to administer medication to the students, she must have the following:

1. Written order from a physician directing the nurse to give medication
2. Written parental permission
3. Medication brought to the Health Office in an original, pharmacy labeled container.
4. Medications must be brought in by a parent/guardian/or a responsible adult and are **NOT** to be sent in on the school bus

Please use the form on the back of this page and have it signed by the physician for your child to have our school nurse administer medication.

We apologize for any inconvenience this may cause, but we must follow state-mandated laws. As always, please feel free to contact the nurse with any questions you might have.

Sincerely,

Kristine Gay, RN
School Nurse

(See reverse side for Physician's Written Order - Student Medication Form)

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AUTHORIZATION FOR ADMINISTRATION OF MEDICATION:

A. TO BE COMPLETED BY THE PARENT OR GUARDIAN:

I request that my child _____ in grade ____ receive the medication as prescribed 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 designated person in case of absence of the school nurse, will administer the medication.

Signature (parent or guardian) _____

Address _____

Telephone: Home _____ Work _____ Date _____

B. TO BE COMPLETED BY THE LICENSED HEALTH CARE PRESCRIBER:

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 AND TITLE (please print): _____

Prescriber's Signature: _____ Date: _____

Address: _____ Phone: _____