TUCKAHOE UNION FREE SCHOOL DISTRICT

HEALTH OFFICE

TO: Parent/Guardians

FROM: The School Nurse's Office

Re: **School Medication Administration**

If your child needs to take medication, either prescription or non-prescription during school hours, you and your doctor must complete the form attached to this letter. Bring the form and the medication to the school nurse. The medication must be in a properly labeled bottle.

If medication is not properly labeled and we do not have signed parent/doctor consent, we cannot give the medication.

We must work together for the health and well being of our students and your children.

If you have any questions, please do not hesitate to call the Health Office at 337-5376 ext. 1236 for TMS/THS or ext. 1282 for Cottle.

Thank you for your cooperation.

Sincerely,
Fiona Higgins RN – W.E. Cottle
Michelle Murray RN -TMS/THS

Reminders:
Be sure that the doctor completes the form. (The doctor may attach an RX form.)
Prescriptions must be in the original container.
Do not send any pill or liquid to school with your child.
Over the counter drugs must be in original container and must follow the above.

Authorization for Medication(s) to be Taken During School Hours

The following section is to be completed by the **PARENT:**

School Name: Please circle one: **W. E. Cottle** **TMS** **THS** Grade:

Child's Name:_____ _____ _____
Last **First** **Sex** **Date of Birth**

I request that my child be assisted in taking the medicine(s) described below at school by authorized persons or permitted to self-medicate her/himself as also authorized by the physician and myself (see below).
Parent/Guardian Signature_____ Date: _____

Home Phone _____ Cell/Work Number: _____

The following is to be completed by the **PHYSICIAN:**
REASON FOR MEDICATION: _____

NAME OF MEDICATION: _____

FORM: _____

DOSE: _____

If medication is give **DAILY,** at what time?_____
If medicine to be given **WHEN NEEDED,** describe indications:
_____
How soon can it be repeated?_____
Is child authorized to self-medicate her/himself? _____
List significant side effects: _____
Length of time this treatment is recommended: _____

OTHER INFORMATION:
_____
_____
_____

Date: _____ Physician Signature: _____

Please print or use stamp.
Physician Name:
Address:
Phone Number:

The law allows any person not necessarily a nurse to assist in carrying out a physician's recommendations, and the school recognizes the desirability of responding to the physician's request. This accommodation on the part of the school is not legally required. Therefore, the persons signing this form are agreeing to hold the school and its personnel free from any and all suits that might arise.