STUDENT HEALTH SERVICES EXHIBIT

Parent and Prescriber's Authorization for Administration of Medication in School

A. To be completed by the parent or guardian:

I request that my child _____ grade _____ receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse will administer the medication or an adult will supervise my child taking his/her own 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 Recommendation: _____

_____

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

_____

Prescriber's Signature _____ Date: _____

Address: _____ Phone: _____

Adoption date: November 12, 2002

STUDENT HEALTH SERVICES EXHIBIT

Self-Medication Release Form

Date: _____

Child's Name: _____

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

_____

_____

We, (Physician's signature) _____

and (Parent/Guardian's signature) _____,

request that (Child's name) _____ be permitted to carry the medication 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 purpose and 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.

Adoption date: November 12, 2002

STUDENT HEALTH SERVICES EXHIBIT

New York State Immunization Requirements For School Entrance/Attendance*

	Pre-Kindergarten ** (Day Care, Nursery, or Pre K)	School (K – 12)
Diphtheria Toxoid Containing Vaccine (DTaP, DTP) ***	3 doses (New York City Schools – 4 doses)	3 doses (New York City Schools – 4 doses)
Polio (IPV) (OPV)	3 OPV or 4 IPV	3 OPV or 4 IPV
Measles Mumps Rubella (MMR)	1 dose of Measles Mumps Rubella (MMR)	Born before 1985 – 1 dose of measles, mumps, rubella (MMR) Born on or after 01/01/85 2 doses of measles containing vaccine and 1 dose each of mumps and rubella (preferably as MMR)
Hepatitis B	Born on or after 01/01/95 3 doses	Born on or after 01/01/93 – 3 doses Grades 7-9****
Haemophilus influenzae type b (Hib)	3 doses if less than 15 months of age or 1 dose administered on or after 15 months of age	Not Applicable
Varicella	Born on or after 1/1/2000***** 1 dose	Born on or after 1/1/98 1 dose

* Demonstrated serologic evidence of measles, mumps, rubella, hepatitis B or Varicella antibodies is acceptable proof of immunity to these diseases. Diagnosis by a physician of a child/student having had measles, mumps or Varicella is acceptable proof of immunity to those diseases.

** Children in a Pre-Kindergarten setting need to be age appropriately immunized. The number of doses depends on the recommended schedule.

*** DTaP is the currently recommended vaccine

**** Hep B – students grades 7-9 – 3 doses of Recombivax HB, Engerix-B or 2 doses of adult hepatitis B vaccine (Recombivax) for children 11 to 15 years old.

***** Varicella is not recommended until 1 year of age

Adoption date: November 12, 2002