

Mahopac Central School District

178 East Lake Blvd., Mahopac, NY 10541-1666 (845) 628-3415 Fax (845) 628-0261

Dear Parent/Guardian

No student is to bring or take medication of any kind in school unless the attached medication permission form is signed by the parent and completed and signed by the doctor.

A student who has an inhalant medication for severe asthma or an Epi-Pen for severe allergy may carry the medication on his/her person or leave it with the school nurse or his/her teacher in the classroom while in class, **IF his/her Doctor** so designates and the attached **Self-Medication Release form is signed by the doctor and the parent/guardian, as well as the Medication form.**

Your son/daughter had medication in school this year. If there is still a need for this medication, please have the medication form completed and returned to the school nurse when school begins in September. If you and the doctor feel your child **MUST** have the medication with him/her at all times, please complete the Self-Medication form as well.

Thank you.

School Nurse

MAHOPAC CENTRAL SCHOOL DISTRICT

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SELF-MEDICATION RELEASE FORM

This form may be used for inhalant medication only.

Date _____

Student Name _____ Grade _____

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

We _____ / _____
Physician Signature *Phone*

and _____ / _____
Parent/Guardian Signature *Phone*

request that _____
Student Name

be permitted to carry the medication on his/her person or leave it with the teacher while in class, as we consider him/her responsible. He/she has been instructed in and understands the purpose of the medication and the appropriate method and frequency of use of this medication. If it is necessary for him/her to use the medication he/she will go to the school nurse immediately for evaluation and consultation regarding the need for any further medical care.

NOTE: If a student and parent request that the student carry his/her own medication this form must be completed in addition to the routine district medication form. New medication forms and self medication forms must be completed each school year.

**MAHOPAC CENTRAL SCHOOL DISTRICT
AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL**

Medication of any kind (aspirin, prescription drugs or any over-the-counter medication) cannot legally be dispensed to any child in school without a doctor's order and parental consent as per New York State Education Law Article 139.

Medications that can be taken at home, before or after school, should be given in this manner.

MEDICATIONS MUST BE RENEWED EACH SCHOOL YEAR. NO STUDENT IS TO BRING OR TAKE MEDICATION OF ANY KIND IN SCHOOL UNLESS THIS FORM IS COMPLETED. Medication must be brought to school by the parent. **MEDICATION NOT PICKED UP BY THE LAST DAY OF SCHOOL WILL BE DISCARDED.**

To comply with this law, any student seen with a medication by any school personnel will have the medication taken from him/her. School administrators and a parent will be notified.

A. TO BE COMPLETED BY THE PARENT OR GUARDIAN:

I request that my child _____ grade _____ receive medication as prescribed by a doctor and furnished by me in the properly labeled original prescription container. The school nurse, or other designated person, will administer the medication.

Signature (Parent/Guardian): _____

Telephone: Home: _____ Work: _____ Date: _____

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

I request that my patient receive the following medication:

Name of Student: _____ Date of Birth: _____

Diagnosis: _____ Medication: _____

Dosage: _____ Frequency: _____ Time Taken in School: _____

Possible Side Effects and Adverse Reactions: _____

Prescriber's Signature / *Date*

PHYSICIAN'S STAMP REQUIRED	
Physician Name _____	
Address _____	