KATONAH-LEWISBORO SCHOOL DISTRICT
MEDICATION FORM

JJHS (914) 763-7205 FAX (914) 763-6572
JJMS (914) 763 -7508 FAX (914) 763-6014
KES (914) 763-7706 FAX (914) 763-7790
IMES (914) 763-7139 FAX (914) 763-7175
MPES (914) 763-7907 FAX (914) 763-7988

ADMINISTRATION OF MEDICATION IN SCHOOL

This form is for **ALL** requests for medication in school. Your physician **MUST** fill in all information below, full name of the medication, frequency and dosage of the medication and reason for the medication. Your signature and your physician's signature at the bottom signify your permission for this medication to be administered in school.

Prescription medication must be in the **original bottle** labeled by a registered pharmacist as prescribed by law. **Over-the-counter medications** must be prescribed by a doctor and must be in their **original unopened containers**. Medication must be delivered to the Health Office by the parent or guardian.

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TO BE COMPLETED BY THE PHYSICIAN:

Name of Student:
_____DOB:_____

Name of medication: _____

Dosage and frequency: _____

Why prescribed: _____

Special directions and/or remarks/side effects: _____

_____

MIDDLE SCHOOL AND HIGH SCHOOL ONLY:

For Emergency medications **ONLY** (Inhalers, Benadryl, Epi Pens, Insulin)

Is this student able to carry and self-administer this medication? (Circle one) **YES** **NO**

PHYSICIAN'S STAMP:

Signature of Physician: _____
Phone number: _____
Date: _____

Parent Signature: _____
Date: _____

Medication orders need to be renewed each school year and MUST be dated after July 1st for the following school year