Westlake Middle School
Health Office

June 2017

Dear Parents/Guardians,

In order to comply with New York State Educational Medication Regulations, all medications given in school, even OVER THE COUNTER MEDICATIONS, must have an order from your doctor. This includes medications such as Acetaminophen (Tylenol), Ibuprofen (Motrin/Advil) Benadryl, Tums, even cough drops .

If your child will be receiving any medications at school, please complete the Medication Authorization form, which allows us to dispense medication to your child in school. This form is located on the Westlake Middle School website. First click "School Nurse", next click Health and Sports Forms, where the Medication Authorization form is found. New York State law requires a new doctor's order form to be completed each school year.

Part "A" is to be completed by you, the parent/guardian. Part "B" must be completed by the prescribing physician. Please bring the form in, with the medication, at the beginning of school. Students are not permitted to bring in their medication, unless it is self-directed.

It is important that this form is completed so your child may be able to have his/her medication in school. If you have any questions, please feel free to call the health office at 914-769-8539.

Sincerely yours,
Lisa Sinkin-Feldman, RN
Dawn McCarrick, RN

MOUNT PLEASANT CENTRAL SCHOOL DISTRICT

825 West Lake Drive
Thornwood, NY 10594

Westlake High/Middle School

PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITES

A. To be completed by the parent or guardian:

I request that my child_____ DOB_____ receive the medication as prescribed below by our physician. **The medication is to be furnished by me in the properly labeled original container from the pharmacy.**

Signature (Parent or Guardian):_____

Telephone: Home_____ Work_____ Date_____

B. To be completed by physician:

I request that my patient, as named below, receive the following medication:

Name of Student_____ DOB_____

Diagnosis:_____ Date_____

Medication_____ Controlled Drug?_____ Yes _____No

Dosage_____ Time of Administration_____

Begin Date_____ End Date_____

Specific Instructions_____

Possible Side Effects and Adverse Reactions:_____

Known Food or Drug Allergies? _____Yes _____No

If yes, specify

PLEASE CHECK ONE:

_____I deem this child can be **SELF-DIRECTED.** I request that the child be permitted to carry his/her medication or keep in locker as we consider him/her responsible. He/she has been instructed in the proper use and understands the purpose and appropriate method and frequency of this medication.

_____I deem this child to be **non self-directed** and understand that administration of oral, topical, inhalant and injectable medications must remain the responsibility of the school nurse, physician, parent or other trained school designated personnel.

Physician's Signature_____ Date:_____

Address_____ Phone_____