KELLENBERG MEMORIAL HIGH SCHOOL
1400 Glenn Curtiss Boulevard • Uniondale, New York 11553-3702
Phone: (516) 292-0200 • Fax: (516) 292-0877 • www.kellenberg.org

PROCEDURE FOR THE ADMINISTRATION OF MEDICATION IN SCHOOL

Dear Parent or Guardian:

In compliance with New York State Education Law the following procedures must be followed for the administration of any prescription and non-prescription medications. The purpose of this procedure is to protect and prevent your child from the possible hazards of sharing medications with other students, losing the medication, and not receiving the medication as prescribed.

PROCEDURE

1. The school nurse must have on file a signed consent from parent/guardian and licensed prescriber. The attached form must be completed.
2. All medications should be delivered directly to the school nurse by parent/guardian.
3. Prescription medications must be delivered in the original prescription container. The pharmacy label must display:
    A. Student name
    B. Name and phone number of pharmacy
    C. Licensed prescriber's name
    D. Date and number of refills
    E. Name of medication/dosage
    F. Frequency of administration
    G. Route of administration and/or other directions
4. Non-prescription medications must be in the original manufacturer's container with the student's name affixed to the container.
5. To carry and self-administer medication, the school nurse must receive a request from a parent/guardian and the licensed prescriber permitting the student to self-administer medication.

The attached form must be completed.

KELLENBERG MEMORIAL HIGH SCHOOL
1400 Glenn Curtiss Boulevard • Uniondale, New York 11553-3702
Phone: (516) 292-0200 • Fax: (516) 292-0877 • www.kellenberg.org

A. To be completed by the parent or guardian:

I request that my child _____ Grade _____ receive the medication as prescribed below by our health care provider. The medication is to be furnished by me in the properly labeled original container from the pharmacy*. I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication, including field trips.

Signature (Parent or Guardian): _____

Telephone: Home _____ Work _____ Cell: _____

Date: _____

B. To be completed by health provider: Date: _____

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

Name of Student _____ DOB _____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE

Duration of Treatment:

Possible Side Effects and Adverse Reactions (if any):

Health Provider's Signature _____ Health Provider's Stamp

Address: _____ Phone: _____

*Medication must be in original pharmacy labeled container with specific orders and name of medication.

*Medication and refills must be brought to school by parent, guardian or responsible adult.

Plan reviewed with parent(s)/guardian(s):

Parent Signature: _____ Date: _____

HO 136B
Revised 6/11

Doctor's Stamp Required

KELLENBERG MEMORIAL HIGH SCHOOL
1400 Glenn Curtiss Boulevard • Uniondale, New York 11553-3702
Phone: (516) 292-0200 • Fax: (516) 292-0877 • www.kellenberg.org

SELF-MEDICATION RELEASE FORM

Date:_____

Child's Name:_____

Has been instructed in the proper use of the following medication procedure:_____

_____

We (Physician's Signature)_____

and (Parent or 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 understand 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***

_____
Physician's Stamp (Required)

Doctor's Stamp Required

HO 136C
Revised 5/10

KELLENBERG MEMORIAL HIGH SCHOOL

1400 Glenn Curtiss Boulevard • Uniondale, New York 11553-3702

Phone: (516) 292-0200 • Fax: (516) 292-0877 • www.kellenberg.org

DAILY MEDICATION LOG

NAME________________________ GRADE________ SCHOOL________________________

MEDICATION AND DOSAGE ____

FREQUENCY and TIME ____________ DATE BEGUN __________ DATE TO END __________

PRESCRIBER'S NAME ____________________________ TELEPHONE NUMBER __________

PARENT'S NAME _______________________________ TELEPHONE NUMBER __________

DATE	TIME	DOSAGE	SIGNATURE	DATE	TIME	DOSAGE	SIGNATURE