

VALHALLA SCHOOL DISTRICT  
VALHALLA, NEW YORK

ADMINISTRATION OF MEDICATION

Dear Parent,

STUDENTS ARE NOT TO CARRY ANY MEDICATION FOR SELF ADMINISTRATION except for asthmatics who use inhalant bronchodilators (for which a copy of this form, completed by parent and physician, must be on file in the Nurse's Office). MEDICATION MUST BE DELIVERED TO THE SCHOOL AND TAKEN HOME BY A PARENT OR GUARDIAN ONLY – THERE WILL BE NO EXCEPTIONS – THIS IS SCHOOL DISTRICT POLICY.

If you wish the school nurse to administer medication to your child during school hours, we require that this form to completed and returned to the school nursing office. Thank you for your cooperation.

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TO BE COMPLETED BY THE PARENT:

I hereby request that the school nurse (or appointed school employee) administer medication as prescribed by my child's physician.

Student's name \_\_\_\_\_ Grade \_\_\_\_\_

Teacher (or Homeroom) \_\_\_\_\_

Parent's daytime telephone number \_\_\_\_\_

Date \_\_\_\_\_ Parent Signature \_\_\_\_\_

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TO BE COMPLETED BY THE PHYSICIAN FOR EVERY MEDICATION

(prescription and over-the-counter)

Patient \_\_\_\_\_ Diagnosis \_\_\_\_\_

Medication \_\_\_\_\_

Dose \_\_\_\_\_ Frequency \_\_\_\_\_

From \_\_\_\_\_ Through \_\_\_\_\_

Initiation Date

Ending Date

Possible Side Effects: \_\_\_\_\_

If P.R.N., signs and symptoms for administering medication:

PRINT M.D., address, telephone number \_\_\_\_\_

Date \_\_\_\_\_ M.D. Signature \_\_\_\_\_

N.Y.S. Reg. # \_\_\_\_\_

**IMPORTANT:** Prescription medication must be in a PRESCRIPTION BOTTLE with a proper pharmacist's label attached. The label should list the student's name, medication and physician. Over-the counter medication is to be labeled with the student's name.

For chronic medications, this form must be renewed annually.