Our mission is to empower all students to be self-directed, lifelong learners, who willingly contribute to their community and lead passionate, purposeful lives.

ARLINGTON CENTRAL SCHOOL DISTRICT
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Dear Parent/Guardian:

Our goal is to provide a safe and healthy environment for all students to learn and grow. In accordance with New York State regulation, students are not permitted to bring medicines to school, receive medicine or self-medicate unless authorized by a physician and supervised by a school nurse.

If medical conditions require a child to receive medication during school hours, a physician must provide a written statement with the following information:

- Name and date of birth of student
- Name of medication, dosage and route of administration
- Frequency and time of administration
- Conditions under which prn (as necessary) medications should be administered
- Special instructions or alert for adverse effects
- Prescriber's name, title, address and phone number
- Prescriber's signature and date

This applies to both “over the counter” and prescription medications.

The only exceptions to the above rules are an inhaler for the treatment of asthma, an EpiPen, Benadryl and Insulin. A physician must still complete the required information, but with a statement that the inhaler, EpiPen, Benadryl or Insulin remain with the child as emergency self-medication to prevent rare but potentially life-threatening situations.

Your physician may use our “Medication Order Form” to authorize the administration of medicine in school. The Medication Order Form is available from your child's school upon request. You may also download it from the Arlington district website. It must be completed and returned before any medication is brought to school. A parent/guardian signature authorizing medication administration must also be provided on the form.

All medication must be transported to school by the parent and maintained in the health office. Unused medication, unless picked up by a parent, will be disposed of at the end of the school year.

With your cooperation, we can provide for your son’s or daughter’s medical needs without endangering their health.

Sincerely,

Dr. Tina DeSa
Assistant Superintendent

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ADDITIONAL MEDICATIONS

Name: ____________________________________________________   Dosage/Frequency: __________________________________________________________

Name: ____________________________________________________   Dosage/Frequency: __________________________________________________________

Medication Order Form

A provider order and parent/guardian permission are required for all medications administered at school and/or school sponsored activities.

Additionally, provider attestation and parent/guardian permission are required for a student to independently carry and use a medication such as inhaled respiratory rescue medication, epinephrine auto injector, insulin, glucagon and diabetes supplies, or other medications requiring rapid administration.

Student Name: ____________________________________________ DOB: ___________ Grade: _______

Health Care Prescriber Medication Order:

Diagnosis: __________________________________________________________________________________________

Medication: __________________________________________________________________________________________

Dose & Route: _________________________________________________________________________________________

Time: ________________________________________________________________________________________________

This medication order is valid for a period of one year unless otherwise specified here:

Provider Permission for Self-Carry/Self-Administration:

☐ No  ☐ Yes, I attest that this student has demonstrated that he or she can self-administer the medication(s) listed above effectively and may carry and use this medication independently at any school/school sponsored activity. Staff intervention and support are needed only during an emergency.

Provider’s Signature__________________________________________ Date ________________

Provider's Name______________________________________________

Provider's Address ____________________________________________

Phone____________________________ Fax__________________________

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Parent/Guardian Permission for Medication

Review and sign only one of the following:

Option A. For a student with provider permission to self-administer and carry.

☐ I agree that my child can self-administer and will carry the medication as prescribed above.

Parent/Guardian Signature_________________________________________ Date__________________

OR

Option B. For a student without provider permission to self-administer and carry. (See above.)

☐ I give permission for my child to receive the medication prescribed above. I understand that I must bring the medication to the school nurse in the original pharmacy or over the counter container.

Parent/Guardian Signature_________________________________________ Date__________________