ALTMAR PARISH WILLIAMSTOWN CENTRAL SCHOOL DISTRICT
639 COUNTY ROUTE 22 • PARISH, NEW YORK 13131
PHONE: (315) 625-5223
FAX: (315) 625-4278

MEDICATION POLICY

FOR YOUR CHILD'S PROTECTION, SCHOOL OFFICIALS ARE PROHIBITED BY LAW FROM ADMINISTERING MEDICINE TO PUPILS.

In urgent cases, however, the school nurse is allowed to cooperate with your family doctor when it is absolutely necessary for a child to have medication while in school.

The following procedures will be strictly followed:

1.) Medication will be given only upon WRITTEN ORDER OF A PHYSICIAN for giving such medication in school. This order should be addressed to the school nurse; and can be requested by the parent right at the doctor's office.

2.) A written request from the parent must also accompany the medication.

3.) Parents are to bring the medication to school and deliver it to the school nurse or main office. Children are not to be left responsible for transporting medication on school buses! ***Medication of any kind found being carried by an elementary school child will be taken and held by the Principal.***

4.) The parent is responsible for an adequate supply of medication in a labeled drug store container. Parents can request two properly labeled containers from the drug store at the time the prescription is purchased.

5.) No change in dosage or frequency will ever be made by the school nurse without the prescribing physician's written order.

6.) Medication includes over the counter medications, such as cough drops, medicated creams & lip ointments, etc.

Medication will not be given to your child in school unless these procedures have been followed.

There are ***NO EXCEPTIONS.***

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MEDICATION PERMISSION FORM

Name ______________________ School Year ____________________________

Dear Parent/ Guardian;

The APW Central School District requires that all students requiring medications during school hours provide the following:

1. **A written statement from the prescribing physician.**
2. **A written consent/request signed by the parent/guardian.**
3. **The medication must be in the original container and labeled.**

TO BE COMPLETED BY THE PHYSICIAN:

Condition being treated ____
Medication prescribed ____
Time, dose, duration to be given ____
Side effects/adverse reactions to be aware of:

____

_______________________________   ___________________________________
Printed Name of Physician   **Signature of Physician**

TO BE COMPLETED BY PARENT/GUARDIAN:

I, ______________________________________, give permission for my child to receive the above medication as directed.

I also give permission for the exchange of information regarding this medication between APW School and the Physician.

______________   _______________   ________________________________
Date   **Phone #**   **Parent Signature**

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SELF-MEDICATION RELEASE FORM

Name ______________________ School Year ____________________________

The above student has been instructed in the proper use of the following medication procedure:

____

____

Physician's signature _________________________ Date:____________________

I request that (Child's name) _______________________ be permitted to carry the above medication on his/her person or to keep in his/her locker, as we consider him/her responsible and knowledgeable about their medications. He/she has been instructed and demonstrates understanding and appropriate method and frequency of use.

Parent/Guardian signature ________________________________ Date: _________________