ARLINGTON CENTRAL SCHOOL DISTRICT

Tina DeSa, Ed.D.
Assistant Superintendent for Pupil Personnel Services
144 Todd Hill Road ● LaGrangeville, NY 12540
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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, Insulin and Glucagon. A physician must still complete the required information, but with a statement that the inhaler, EpiPen, Benadryl, Insulin and Glucagon 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

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
144 Todd Hill Road ● LaGrangeville, NY 12540
Phone: 845-486-4460 ● Fax: 845-350-4051

Date:

Dear Health Care Provider,

As of 7/1/15, providers who wish to permit students to **independently carry and use** their own medications which require rapid administration during the school day/school sponsored events, will need to attest (state in writing), that they have observed the student using those medications correctly.

The Laws pertaining to this are sections **916, 916a** and **916b** and **136.7** of NYS Commissioners Regulations.

The attestation requirement is a change in previous practice for private health care providers. We understand that many providers use specific paper or electronic forms for medication requests at school. To assist providers and schools, we have created a form which may be used to document the attestation which can be appended to any original order provided. Providers may wish to incorporate the attestation language into their existing forms so that the addendum is not needed in future requests.
Attestation indicates that the student is independent in their medication use with no assessment or intervention needed by school staff. If school staff believes the student is not appropriately and consistently taking their medication, it should be documented and parents/guardians notified.

Our school will be **required by law** to obtain an attestation in order to allow students to independently use and carry their medication at school, and may contact you for this additional information if not supplied with the original order.

We appreciate your time in collaborating with us to allow your patient and our student to use their medication independently at school as you have requested.

Sincerely,

School Nurse

Phone:_____ Fax: _____

Email: _____

Arlington Central School District
144 Todd Hill Road
LaGrangeville, NY 12540
Phone 845-486-4460
Fax 845-350-4051

Medication Order Form

A **provider order** and **parent/guardian permission** are required for all medications administered at school and/or school sponsored activities. ***This medication order is valid for a period of one year.***

Student Name_____ **DOB**_____ **Grade/Class**_____

Health Care Prescriber Medication Order:

Diagnosis: _____

Medication: _____

Dose & Route: _____

Time: _____

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.**

Provider Permission for Self- Administration and Carry:

❒ **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_____

Provider Stamp

****

Parent/Guardian Permission for Medication

Review and sign <u>only one</u> of the following:

Option A. For a student <u>with</u> 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 <u>without</u> 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_____