Rush-Henrietta Central School District

MEDICATION ORDER FORM FOR SCHOOL-SPONSORED OVERNIGHT AND INTERNATIONAL FIELD TRIPS

1. A signed medication form must be completed by the doctor and signed by the doctor and the parent before medication can be carried by the student and/or by the school staff.
2. Parents are to bring in and take home all prescription medications unless student is deemed **Independent** as described below. Medication provided for the school day cannot be sent on overnight field trips; overnight field trip medication and permission form must be supplied separately from school medications by the parent.
3. Medicine must be counted by the parent and brought to the Health Office in the original medication bottle. (Pharmacies can supply an extra labeled prescription bottle for this purpose)
4. It is recommended that you send only as much medicine as the student will require on the trip.
5. **Note: New York State and the District recommend that medication(s) that do not require rapid administration should be kept in the custody of a nurse or staff member. CONTROLLED SUBSTANCES CAN ONLY BE CARRIED BY NURSE/DESIGNATED STAFF MEMBER. Students may carry medications and self-administer only if the following conditions have been satisfied:** (1) The following form is completed; (2) You have educated your daughter/son in regard to responsible usage of this medication; (3) The student is found to be responsible by school officials; (4) Only a one-day supply is carried, except for inhalers; (5) If irresponsible use is noted, the privilege will be rescinded.

HEALTH CARE PROVIDER ORDER AND PERMISSION

Student Name_____DOB_____Grade_____Date _____

Definitions of medication assessment for Provider Attestation:
Independent student: Has demonstrated that they can self-administer the medication(s) safely and effectively and may carry and use these medications independently at school or any school sponsored event.
Supervised student: Requires oversight of self-administration of these medications by a nurse or delegated unlicensed school staff as directed by the student.

This child is under my care and requires the following medication during school day:

Please print all information

Diagnosis				
Name of Medication				
Dosage & Route				
Frequency				
Possible Side Effects				
Requires rapid administration	Yes/No Please circle	Yes/No Please circle	Yes/No Please circle	Yes/No Please circle
Medication Attestation (see above for definitions)	☐ Independent ☐ Supervised	☐ Independent ☐ Supervised	☐ Independent ☐ Supervised	☐ Independent ☐ Supervised

_____ _____
Prescriber's Signature Print Prescriber Name and Title

Prescriber's Phone number: _____ Fax: _____

I, as the parent/guardian of this student, agree that my child can receive these medications as delegated by their HealthCare Provider above and per the school SNT or RN.

_____ _____
Parent/Guardian Signature Print Parent/Guardian name

Parent Contact Number: (____)_____(Home) (____)_____(Cell)