LIVONIA
Central School District

P.O. Box E
Livonia, NY 14487-0489
www.livoniacsd.org

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MEDICATION INFORMATION AND POLICIES

Livonia Central School District

If you wish your child to receive ANY medication at school, the New York State regulation requires written permission from your health care provider and parent. This includes all prescriptions and/or over-the-counter medications.

- Nurses may administer medication only at the time(s) (with a variance of one hour before and one hour after) and the dosage specified by the healthcare provider.
- Medication must be properly labeled with specific directions and dose, **in the original container**.
- **New forms are required at the beginning of each school year and whenever the dosage changes.**
- All medication must be brought in and picked up at the end of the school year **by an adult**. Any medication not picked up will be discarded on the last day of school.
- If half pill dosage is required, please bring pills to school cut in half. Childproof caps are not required.
- Mid-day medications are not administered on school half days unless specifically requested by the parent.

Please Note: The New York Board of Pharmacy requires schools to send medications on extended field trips in a pharmacy labeled bottle. Please ask your pharmacist for an extra empty bottle when the prescription is being filled (i.e. one bottle for home, two for school).

Grade Level:_____

MEDICATION AUTHORIZATION FORM

Livonia Central School District

For School Year 20___- 20___

(Parent and Prescriber's Authorization for Administration of Medication in School)

ORDERS FOR: ____/___________________/__________

Name DOB Weight

Medication/Food Allergies: ____

If you wish your child to receive **ANY** medication at school, the **New York State regulation requires written permission from your health care provider and parent**. This includes all prescriptions and/or over-the-counter medications. This written permission must be renewed annually. **All non-prescription medications MUST be in new un-opened bottles. Prescription medications must have actual prescription labels on them, as well as Epi-pens and inhalers with the sticker on them for safety reasons**. Administration of over-the-counter medications will be "per label" directions for age/weight unless otherwise indicated by provider.

Drug Name	Provider Order	Drug Name	Provider Order
Neosporin (antibiotic ointment)	☐Yes ☐No	Throat Lozenges (throat irritation)	☐Yes ☐No
Benadryl (allergies) or generic	☐Yes ☐No	Tums (heartburn, stomach upset)	☐Yes ☐No
Cortisone Cream (topical) for skin irritation	☐Yes ☐No	Visine (regular and allergy) for eye irritation	☐Yes ☐No
Cough Drops	☐Yes ☐No	Other:	☐Yes ☐No
Ibuprofen (fever/discomfort)	☐Yes ☐No	Other:	☐Yes ☐No

Prescription Medications to be Given in School

Drug Name	Dose	Directions	Reason

Physician please check if applicable:

☐ If morning dose is missed at home, RN may administer morning dose of _________________________with parent permission
☐ Medication **should be** taken on field trips
☐ Medication **should be** given during school sponsored after school and/or weekend activities/sports

ALL MEDICATION MUST BE PROVIDED BY PARENT

PARENT/GUARDIAN AUTHORIZATION REQUIRED

Signature: ____________________________________

Phone Number: ________________________________

Date: ____

DOCTOR'S AUTHORIZATION REQUIRED________

Signature: ____________________________________

Phone Number: ________________________________

Date: ____

Lori Allen, RN – Elementary School fax: 346-4038
Debbie Sanderson, RN – Middle School fax: 346-4053
Judy Hennekey, RN – Senior High School fax: 346-4059

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PROVIDER ATTESTATION AND PARENT PERMISSIONS REQUIRED FOR INDEPENDENT MEDICATION CARRY AND USE

Directions for the Health Care Provider: This form may be used as an addendum to a medication order which does not contain the required diagnosis and attestation for a student to independently carry and use their medication as required by NYS law. A **provider order** and **parent/guardian permission** is needed in order for a student to carry and use medications that require rapid administration to prevent negative health outcomes. These medications should be identified by checking the appropriate boxes below.

Student Name: ____________________________________ **DOB:** ____________________

Health Care Provider Permission for Independent Use and Carry

I attest that this student has demonstrated to me that they can self-administer the medication(s) listed below safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency. This order applies to the medications checked below:

This student is diagnosed with:

- ☐ Allergy and requires Epinephrine Auto-injector
- ☐ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication
- ☐ Diabetes and requires Insulin/Glucagon/Diabetes Supplies
- ☐ _______________________ which requires rapid administration of _________________
  (State Diagnosis) (Medication Name)

Physician Signature: __________________________________ Date: _______

Parent/Guardian Permission for Independent Use and Carry

I agree that my child can use their medication effectively and may carry and use this medication independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency.

Signature: ______________________________________ Date: ___________________