

Christian Central Academy

MEDICATION POLICY and PROCEDURES

Dear Parents/Guardians:

The New York State Department of Education has established the following procedure by which medication may be administered in school:

“ALL MEDICATION, INCLUDING NON-PRESCRIPTION DRUGS (*Tylenol, Motrin, cough drops, ointments, etc.*), **GIVEN IN SCHOOL SHALL BE PRESCRIBED BY A LICENSED PRESCRIBER ON AN INDIVIDUAL BASIS AS DETERMINED BY THE CHILD’S HEALTH STATUS.”**

Medication Permission Forms are available in the Health Office or the information may be outlined by your child’s physician. Specific requirements for the administration of internal medication in school are as follows:

- 1) The school nurse must have a **written request from the child’s physician** that indicates the **medical condition** being treated and the length of time the medication is to be administered. In addition, the form must specify the name of the drug, the dosage, the frequency and time to be administered, the route, and the potential side effects.
- 2) The nurse must have a **written request from the parent** to administer medication as specified by the physician. A verbal or telephone request from the parent or physician is not acceptable.
- 3) **PRESCRIPTION MEDICATION:** Must be in the container prepared by the pharmacist and the label must include the name and strength of the medication. (*NOTE: The PHARMACY LABEL DOES NOT CONSTITUTE A WRITTEN ORDER and cannot be used in lieu of a written order from a licensed prescriber.*)
- 4) **NON-PRESCRIPTION MEDICATION:** Over the counter (OTC) medications must be in the sealed original manufacturer’s container with the student’s name affixed to the container. Medication delivered in baggies or plain containers is NOT acceptable.
- 5) All medication must be delivered directly to the nurse by the parent. **NO MEDICATION SHOULD BE SENT TO SCHOOL WITH THE CHILD**. NO MEDICATION IS TO BE CARRIED ON THE BUS.
- 6) Medication orders must be renewed annually or whenever there is a change in dosage or frequency.

These procedures are designed to protect the safety of all pupils. Medication sent to school that does not meet the above requirements will be kept in the Health Office and WILL NOT be administered. Parents will be notified to pick up this medication. Any unused medication will be disposed of if not picked up within a reasonable length of time.

If you have any questions about these requirements, please call the school nurse at **634-4821**.

Williamsville Central School District & *Christian Central Academy* Nurses

LI-LO-LI MEDICAL PACKET

*(Must be completed if you checked OPTION #2,
MEDICATION NEEDS portion on Permission Form.)*

To be compliant with New York State Law,
the following medical information
MUST be completed.

**NO ONE CAN ADMINISTER
ANY MEDICATION
WITHOUT THE FOLLOWING
AUTHORIZATION FORM
COMPLETED.**

This includes **ALL over-the counter medications**
such as *aspirin, allergy or sinus medications, etc.*

(Please note the fax number on the bottom of the form)

PERMISSION FORM to attend LI-LO-LI RETREAT

Complete both sides (bottom only of this side if applies)
and return to school

Student's Name: _____ Grade: _____

I do hereby grant permission for _____ to accompany other CCA students, faculty, and chaperones to:

Camp Li-Lo-Li
Thursday, September 15 & Friday, September 16, 2011
From 9:00 AM (9/15) – 3:00 PM (9/16)

In signing this form, I do take full responsibility for any and all injuries sustained by this student while in the care of CCA appointed chaperones and camp personnel. I do so with the agreement that such activities are properly organized and supervised.

Parent Signature _____ Date: _____

PAYMENT: Enclosed is payment of \$_____.

Make checks payable to: CHRISTIAN CENTRAL ACADEMY Cash Check # _____

Please note: This is not an optional activity. We are "taking a school day and moving it to a different location." Should your child be **unable to attend**, a **written excuse** as per New York State attendance law ASAP, that we might make adjustments in our accommodations. We do not want any student to miss due to a financial hardship. Please contact **Mrs. Williams** by phone 634-4821 or a written note, if this is the case.

MEDICATION NEEDS (Complete if applies)

OPTION 1:

_____ My child has medication at school and a completed *Parent & Prescriber's Authorization to Administer Medication in School form** is on file.
(check if applies) The school nurse will send that medication to Li-Lo-Li.

AND /OR

OPTION 2:

_____ I have reviewed the Li-Lo-Li Medical Packet and will complete and return the
(check if applies) *Parent & Prescriber's Authorization to Administer Medication in School** form by **Friday, September 9**. (Form can be returned sooner.)
I will bring any **medication to school by 8:20 AM, Thursday, September 15** that my child will need. Clear directions and times, with MD orders, will be attached.

Students are not allowed to bring medications to school by law.

NOTE: All prescription and non-prescription medication must be in the original container. Enclosed is the *Parent & Prescriber's Authorization to Administer Medication in School** form. This form **must** accompany medications unless it is already on file in the nurse's office. (*Please note: *form must be signed by the doctor!*)

(Please complete other side)

AUTHORIZATION for MEDICAL TREATMENT of MINORS

(IN CASE OF EMERGENCY ONLY)

Name of Minor:

_____ Date of Birth: _____

List ALLERGIES or SPECIAL CONDITIONS:

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I / We, being parent(s) or legal guardian(s) of the above named minor, do hereby appoint:

Name: *Christian Central Academy* Staff  
Address: 39 Academy Street, Williamsville, NY 14221  
Phone: (716) 634-4821

to act in my / our behalf in authorizing unexpected medical, dental, surgical care or hospitalization for the above named minor during the period of my / our absence from:

**September 15, 2011 through September 16, 2011**

This document shall be presented to a physician, dentist, or appropriate hospital representative at such time as unexpected medical, dental, surgical care or hospitalization may be required.

\_\_\_\_\_  
(Parent / Guardian Signature)

\_\_\_\_\_  
(Parent / Guardian Signature)

Address: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

HOSPITALIZATION COVERAGE for ABOVE NAMED MINOR

\_\_\_\_\_  
(Insurance Company or Government Program)

\_\_\_\_\_  
(ID or Contract Number)

\_\_\_\_\_  
(Insurance Company or Government Program)

\_\_\_\_\_  
(ID or Contract Number)



CHRISTIAN  
CENTRAL  
ACADEMY

QUALITY EDUCATION - CHRISTIAN VALUES

**PARENT and PRESCRIBER'S AUTHORIZATION  
for ADMINISTRATION OF MEDICATION IN SCHOOL**

*Authorization for Administration of Medication*  
**Prescription and over the counter**

**A. To be completed by the parent or guardian:**

I request that my child \_\_\_\_\_ Grade \_\_\_\_\_ receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse will administer the medication or an adult will supervise my child taking his/her own medication.

I understand also that a child who is self-directed can carry and self-administer medications for asthmatic or severe allergic conditions. Separate health office forms/assessment required. Please contact the school Health Office for more information.

Signature (Parent or Guardian): \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: HOME: \_\_\_\_\_ WORK: \_\_\_\_\_ DATE: \_\_\_\_\_

**B. To be completed by the licensed health care prescriber:**

I request that my patient, as listed below, receive the following medication:

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Prescribed Dosage, Frequency and Route of Administration:  
\_\_\_\_\_

Time to be taken During School Hours: \_\_\_\_\_

Duration of Treatment: \_\_\_\_\_

Possible Side Effects and Adverse Reactions (if any): \_\_\_\_\_  
\_\_\_\_\_

Other Recommendations: \_\_\_\_\_  
\_\_\_\_\_

**Name of Licensed Prescriber and Title** (please print): \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Prescriber's Address: \_\_\_\_\_ Phone: \_\_\_\_\_

