# Roslyn Public Schools

East Hills School 400 Round Hill Road Roslyn Heights, NY 11577
Phone: 516-801-5300 FAX: 516-801-5308 www.roslynschools.org

Melissa Krieger
Principal

Nichole Lewis
Assistant Principal

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Dear Parent(s)/Guardian(s):

Due to recent regulations regarding school-nursing procedures, teachers and other staff members are not permitted to dispense medication. This includes subcutaneous, intramuscular, intravenous or rectal medications administered through pumps, tubes or nebulizers, or oral, topical or inhalant medications, including over-the-counter medications. Students who receive medication in school presently receive their medication from the school nurse; however, during field trips and after-school activities, the school nurse is not available.

Students may be self-directed to take medication. By New York State Education Department's definition, this means "Individual who is capable and competent to understand a personal care procedure, can correctly administer it to him/herself each time it is required, has the ability to make choices about the activity, understand the impact of these choices and assumes responsibility for the results of the choices . . . " Students who are self-directed do not require a nurse to administer medication, but may carry it him/herself, or ask a staff member to hold it until it is needed. Parents of students who are self-directed may opt to keep medication in the nurse's office.

Non-self-directed students who require medication on a field trip or at after-school activities may only be administered medication by a parent or a nurse. Because of this, parents of children requiring medication will be requested to accompany their children during these activities and field trips. If a parent cannot accompany their child, a substitute nurse will be sought to accompany the child during the activity or field trip. Because of the large number of field trips, it may not always be possible to obtain the services of a nurse. In this case, the field trip or activity may have to be postponed or cancelled if alternative arrangements cannot be made.

Enclosed is a self-direction form. If you and your child's physician feel that your child may be self-directed, please complete the form and return it to your child's classroom teacher or the East Hills' school nurse. This will facilitate our planning for field trips and activities.

If you have any questions, please call the school nurse, Mrs. Elaine Kerr, at 801-5310.

Sincerely,

*Melissa Krieger*

Melissa Krieger
Principal

MK/sd
Enclosures

ROSLYN PUBLIC SCHOOLS
ROSLYN, NEW YORK 11576

# SELF-MEDICATION RELEASE FORM

Date: _____

Student's Name: _____ Date of Birth: _____

Grade: _____ Phone Number: _____

has been instructed in the proper use of the following medication procedures (list medications)

_____

_____

We (physician's signature) _____

and (parent or guardian's signature) _____

| Physician | Parent |
|---|---|
| Print name: _____ | Print name: _____ |
| Address: _____ | Address: _____ |
| _____ | _____ |
| Phone No.: _____ | Phone No.: _____ |
| Date: _____ | Date: _____ |

request that (student's name) _____ be permitted to carry the medication on his/her person or to keep same in his/her locker or P.E. locker, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency or use. The child and parent may also opt to maintain the medication in the nurse's office.

Check one:

_____ Student will carry medication in a properly labeled container and self-administer. NOTE: It is the parent's responsibility to monitor on an ongoing/daily basis that the student is carrying and taking medication as directed.

_____ Student will keep medication supply in the Health Office to be administered by nurse and self-administer only as needed on field trips and after-school activities. (In this case the "Permission for Administration of Medication in School" form must be completed.)

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ROSLYN, NEW YORK 11576

Department of Health, Physical Education and Recreation

**PERMISSION FOR ADMINISTRATION OF MEDICATION IN SCHOOL**

Dear Parent(s)/Guardian(s):

The State law requires that we have the following information for any student who must take medication in school:

Name of Student _____ Address _____

Teacher _____ Grade _____ Medication _____

Duration of Therapy _____ Dosage _____ Time _____ Route _____

Diagnosis: _____ PRN or Scheduled?

Side effects of this medication are _____

_____

Address of Physician _____ Signature of Physician _____ Date _____

Telephone Number of Physician _____ Name of Physician (Printed) _____

TO BE FILLED OUT BY PARENT

I hereby give permission to the School Nurse or designee to administer the above medication,

according to the above instruction to

_____
Name of Student

_____ _____
Signature of Parent or Guardian Date