Eastern Suffolk BOCES

Extended Day Enrichment Program

Educational Support Services

MEDICATION AT THE PROGRAM

A. To be completed by the parent or guardian:

I request that my child ______________________________DOB ____________ receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy.

Signature (Parent or Guardian): ____

Telephone: Home _________________ Work ________________ Date __________________

B. To be completed by physician:

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

Name of Student _________________________________ DOB ______________________________________

Diagnosis: ____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment: ____

Possible Side Effects and Adverse Reactions (if any): ____

PLEASE CHECK ONE:

☐ I deem this child to be **self-directed** and understand that the school nurse, or other designated person in the case of the absence of the school nurse, will dispense the medication, including field trips.

☐ Student **may self-carry and administer** his or her own inhaler and/or Epi-Pen **only**.

☐ I deem this child to be **non self-directed** and understand that administration of oral, topical, inhalant and injectable medications must remain the responsibility of the school nurse, licensed practical nurse under the direction of a school nurse, physician, or parent.

Physician's Signature/Stamp: ____ Date: ______________________

Physician's Phone: _____________________

* Medication must be in original pharmacy labeled container with specific orders and name of medication.

* Medication and refills must be brought to school by parent, guardian or responsible adult.