MOUNT SINAI MIDDLE SCHOOL

114 NORTH COUNTRY ROAD, MOUNT SINAI, NEW YORK 11766
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Ms. Elizabeth E. Hine
PRINCIPAL

Ms. Melissa K. Drewisis
ASSISTANT PRINCIPAL

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SUPERINTENDENT

2021 – 2022 HEALTH OFFICE NOTICE

Please return the enclosed forms no later than
March 1, 2022

January 18, 2022

Dear Parents/Guardians:

The Mount Sinai School District has procedures/policies that must be adhered to regarding the dispensing of medications in school and on school trips. These procedures/policies are based upon the New York State Education Laws and the Nurse Practice Act. These procedures/policies apply to all prescription medications as well as over the counter medications.

The attached forms require your consent along with a physician's prescription for any over the counter medication or prescription medication your child might need to take.

1. The *School Trip Health Form* must be filled out completely and signed by a Parent/Guardian.
2. The *Parent/Physician Authorization for Administration of Medication for In-School Use and on School Trips.* **Parents/Guardians are to complete Part A. The physician is required to complete Part B.**
3. If your child will carry and administer his/her own medication, the *Self-Medication Release Form,* in addition to the *Parent /Physician Authorization for Administration of Medication on School Trip Form*, must be completed and signed by the Parent/Guardian and Physician.
   - ***Self-Medication Release Form A*** is for all prescription medication as well as over the counter medication.
   - ***Self-Medication Release Form B*** is to be used strictly for Epi-Pens, Inhaled Respiratory Rescue Medication, and for diabetes requiring insulin, Glucagon and/or diabetic supplies.

If your child will be self-carrying their medication, please pack the medication in your child's carry-on bag and be sure that the medication is in a properly labeled pharmacy container or the original over the counter container.

PLEASE NOTE: ***NO MEDICATION OF ANY KIND WILL BE DISPENSED UNLESS THE ABOVE PROCEDURES/POLICIES ARE FOLLOWED.***

Sincerely,

Elizabeth E. Hine

Enc.

cc: Mr. Scott Reh

MOUNT SINAI UNION FREE SCHOOL DISTRICT
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SCHOOL TRIP HEALTH FORM

THIS FORM MUST BE FILLED OUT COMPLETELY, SIGNED BY A PARENT OR GUARDIAN AND RETURNED TO THE HEALTH OFFICE.

(Please print all information.)

Student's Name: _____ Date of Birth: _____ Grade: _____

Name of Parent/Guardian: _____ Home Phone: _____

Address: _____ Bus. Phone: _____

Parent/Guardian Cell Phone Numbers: _____ _____

Alternate contact in case of emergency:

Name: _____ Relationship to Student: _____

Phone Number: _____ Bus. Phone: _____

Physician's Name: _____ Phone: _____

Medical Insurance Co.: _____ Policy #: _____

My student is allergic to the following: _____

****PARENT AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT****

As parent/legal guardian of _____, I hereby give permission to the Mount Sinai School chaperones to authorize medical treatment by a physician or hospital for my child while on all the school trips.

I understand that every possible attempt will be made to notify me before any treatment is authorized.

_____ _____
Date *Signature of Parent/Guardian*

PLEASE RETURN THIS FORM TO THE NURSE'S OFFICE.

Updated 1/2022

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PARENT/PHYSICIAN AUTHORIZATION FOR ADMINISTRATION OF MEDICATION
FOR
IN-SCHOOL USE AND SCHOOL TRIPS

A. To be completed by Parent/Guardian: **Grade Level** _____

I request that my child, _____, receive the medication as prescribed by my physician.

Name of Parent/Guardian *(Please print.)*: _____

Signature of Parent/Guardian: _____ Date: _____

Home Phone: _____ Cell Phone: _____

B. To be completed by Physician:

Allergies: _____

I request that my patient, as listed below, receive the following medication (prescription and over-the-counter):

Name of Student (*Please print.*): _____

1. Diagnosis: _____ Medication: _____

   Dosage, Frequency, Route, Time & Side Effects:

   _____

   _____

2. Diagnosis:_____ Medication: _____

   Dosage, Frequency, Route, Time & Side Effects:

   _____

   _____

Name of Physician *(Please print.)*: _____

Address: _____

Signature/Stamp: _____ Date: _____

This form must be completed for students to carry and administer their own medication (prescription and over-the-counter) in school and on school trips along with the Self-Medication Release Form (A or B as applicable).

Updated 1/2022

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SELF-MEDICATION RELEASE

FORM A

Grade Level: _____

Student's Name *(Please print.)*: _____ has been instructed in the proper use of the following medication procedures:

Name of medication: _____

Procedures: _____

_____

_____

_____

We request that the above named student be permitted to carry the medication on his/her person. We consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use.

_____ _____
Signature of Physician *Date*

_____ _____
Signature of Parent/Guardian *Date*

NOTE:
This form must be completed in addition to the ***Parent/Physician Authorization for Administration of Medication for In-School Use and on School Trips*** for those students who request permission to carry and administer their own medication (prescription and over-the-counter) on school trips.

Updated 1/2022

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SELF-MEDICATION RELEASE

FORM B

PROVIDER 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's Name: _____ **DOB:** _____

Grade Level: _____

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 with no supervision by school staff. 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)

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 with no supervision by school staff.

Signature: _____ Date: _____

Please return to the School Nurse:

School Nurse:		School:
Phone #:	Fax:	Email:

NOTE: This form must be completed in addition to the *Parent/Physician Authorization for Administration of Medication for In-School Use and on School Trips* for those students who request permission to carry and administer their own medication (prescription and over-the-counter) on school trips.

Updated 1/2022