

Date of Request \_\_\_\_\_

Student Name \_\_\_\_\_

**BLUE SHEET**

**MASSAPEQUA PUBLIC SCHOOLS**

**ADMINISTRATION OF MEDICATION IN SCHOOL  
REQUEST FORM**

Name of Student \_\_\_\_\_ DOB \_\_\_\_\_

In accordance with Board of Education policy, Superintendent's regulation, and New York State Education Department guidelines, the Massapequa Schools require the following information in order to fulfill requests for the administration of medication during school hours:

**TO BE COMPLETED BY PRESCRIBING PHYSICIAN**

Name of Medication \_\_\_\_\_ Dosage \_\_\_\_\_

Purpose of Medication \_\_\_\_\_

Specific time or circumstances for administration \_\_\_\_\_

Period for which medication is subscribed (if applicable) \_\_\_\_\_

Possible side effects (if applicable) \_\_\_\_\_

\_\_\_\_\_  
Printed Name of Prescribing Physician

\_\_\_\_\_  
Signature of Prescribing Physician

\_\_\_\_\_  
Date

- All medications will be administered by the school nurse or their designees.
- Medication must be provided to the school nurse in its original labeled container, specifying the name of medication, dosage, and time/circumstances for administration
- Medication must be brought to the school nurse by the parent/guardian and picked up at the end of the period of medication or school year. Medication that is not picked up within five days shall be discarded.
- Students who are self-directed in the administration of their medication may be provided the opportunity to do so during school. A separate form is required for this purpose, which is available in the health office.

**TO BE COMPLETED BY PARENT/GUARDIAN**

I have read and understand the above information, and give permission for the district to administer medication to my son/daughter as per the directions above.

\_\_\_\_\_  
Printed Name of Parent/Guardian

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date