Bethlehem Central School District Health Services

High School Phone # 439-4967
High School Fax # 475-9243
Middle School Phone # 439-7705
Middle School Fax # 475-0513

Medication Administration Policy

- The administration of prescribed medication to a student during school hours shall be permitted only when failure to take such medicine would jeopardize the health of the student, or the student would not be able to attend school if the medicine were not made available to them during school hours, or where it is done pursuant to law requiring accommodation to a student's special medical needs.

- Written parent permission and written orders from a medical provider are needed for both prescribed and over-the-counter medications in school.

- A written order from the prescribing medical provider, should include the purpose of the medication, the dosage, the time at which or the special circumstances under which medication shall be administered, the period for which medication is prescribed, and the possible side effects of the medication.

- The medical provider order must be renewed each school year or when there is any change in the order.

- The parent/guardian is responsible to have the medication delivered directly to the nurse in a properly labeled, original pharmacy container or packaging (for over-the-counter medications), by an adult.

- All controlled substances must be brought to the nurse by an adult. The medication will be counted and recorded.

- Schools take temporary and incidental possession of medications at the request of the parent/guardian. Therefore, medications should be returned to the parent/guardian when no longer needed at school. Medications remaining at the end of the school year will be disposed of in accordance with NYS Department of Environmental Conservation recommendations.

- Self-Carrying Emergency Medications: Students with a valid medication order as well as a signed medical and parent attestation (see Emergency Medication Authorization Form) can carry and self-administer the following medications on school property and at any school functions:
  - Inhaled rescue medications for respiratory symptoms
  - Epinephrine auto-injector to treat allergies
  - Insulin, glucagon, and other diabetes supplies to manage Diabetes

Bethlehem Central School District Health Services

High School Phone # 439-4967
High School Fax # 475-9243
Middle School Phone # 439-7705
Middle School Fax # 475-0513

EMERGENCY MEDICATION FORM

Authorizations for school medication administration

*For students to self-carry and use medications that require rapid administration of **Epinephrine, Inhaler, Insulin/Glucagon** the following are required: Health Care Provider Order, Health Care Provider Attestation and Parent/Guardian Permission*

(This form is only for Epinephrine, Inhalers, Insulin/Glucagon)

Student Name: _____ **DOB:** _____ **Grade:** _____

THIS SECTION TO BE COMPLETED BY HEALTH CARE PROVIDER

I request that my patient, as listed above, receive the following medication(s):

MEDICATION(S)	DOSAGE/ ROUTE	FREQUENCY/ TIME TO BE GIVEN	REASON FOR MEDICATION	DURATION OF TREATMENT

Possible Side Effects/Adverse Reactions: _____

☐ PROVIDER INITIALS — **YES**, I attest that this student has been instructed and demonstrated to me that they can self-administer the medication(s) listed above safely and effectively; and, they 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, either on their person or in their locker.

☐ PROVIDER INITIALS — **NO**, I do not attest to the above statement. Student's medication should be kept in the health office.

Provider Signature: _____

Provider Name & Title (Printed or Stamp): _____

Office Phone Number: _____ **Date:** _____

THIS SECTION TO BE COMPLETED BY PARENT OR GUARDIAN

I request that my child receive the medication(s) as prescribed above by my child's licensed health care provider. Medications will be furnished by me in the properly labeled, original container, from the pharmacy/store. I have read and understand the Medication Administration Policy outlined on the previous page.

I agree that my child can use their medication effectively and may carry and use this medication independently at school/school sponsored activities with no supervision by school staff. I will be responsible to ensure my student is carrying their medication responsibly and as ordered.

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____

Daytime Phone Number: _____ **Date:** _____

Updated: June 2025