The mission of the Three Village Central School District, in concert with its families and community, is to provide an educational environment which will enable each student to achieve a high level of academic proficiency and to become a well-rounded individual who is an involved, responsible citizen.

THREE VILLAGE
CENTRALSCHOOL DISTRICT

Minnesauke Elementary School

Brian Biscari, Principal
Patricia Essenfeld, Assistant Principal

Dear Parents or Guardians,

Throughout the school year the physical education program routinely includes both cardiovascular and endurance training. It is a well balanced program that challenges the children at many levels.

Children who have any form of asthma may struggle and not be able to enjoy their physical education class or their recess period to its fullest due to breathing difficulties.

The health office receives many inhalers during the spring season in preparation for the mile run. We ask that you consider providing an inhaler so your child may utilize it during the entire school year for optimum comfort.

Please scroll down for the N.Y. State requirements and Administration for Medicine form to be completed by you and your child's physician.

If you have any questions, please call the health office.

Thank you,

Nancy Weiner, R.N.
631 730-4210

Dino Amatulle, PE
Danielle Cumings, PE
Ron Muscarella, PE

Dear Parent or Guardian:

Frequently the school nurse is asked to administer medication to a student during school hours. The Three Village School District will allow this under specific conditions.
These conditions are:

1. A written request from a parent giving permission for administration of medication.

2. A written request must be submitted by the prescribing physician that includes the purpose of the medication, the dosage, the time at which or special circumstances under which medication shall be administered, the period for which medication is prescribed, and the possible side effects of the medication.

3. The medication must be in the original container identified for your child. The label must include name of doctor, name of the student, name of the medication, amount to be administered and when it is to be administered.

4. Only an adult may transport the medication to the Health Office, and only an adult may pick up any remaining medication at the end of the school year, or the end of the period of administration, which ever is earlier. All medication not picked up within five days of the period of administration will be discarded.

Students **will not** be permitted to take any medication if the established procedures are not followed. This includes over the counter drugs such as Tylenol, aspirin, throat spray, etc.

It is the responsibility of the student to report to the Health Office at the prescribed time for the purpose of receiving the medication.

This procedure must be repeated at the beginning of each school year whenever there is a case of continued need for medication.

If you have any questions concerning our district policy, please feel free to call 730-4210 any time.

Sincerely,

Nancy Weiner, R.N.
School Nurse

THREE VILLAGE CENTRAL SCHOOL DISTRICT

PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

Authorization for Administration of Medication

A. To be completed by the parent or guardian:

I request that my child ____________________________________grade____________ receive the medication as prescribed below by our physician. The medication is to be furnished by me in properly labeled original container from the pharmacy. I understand that the school nurse or other designated person in the case of the absence of the school nurse will administer the medication.

Signature (Parent or Guardian): ____

Address: ____

Telephone: Home __________________ Work __________________ Date _______________

B. To be completed by the physician:

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

Name of Student: ____Date of Birth: _____________

Diagnosis: ____

Name of Medication: ____

Prescribed Dosage, Frequency & Route of Administration: _________________________________

____

Time to be taken during the school hours: ____

Duration of Treatment: ____
(UNLESS OTHERWISE SPECIFIED, THIS ORDER WILL BE GOOD UNTIL AUGUST 31 OF THE CURRENT SCHOOL YEAR)

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

Other Recommendations: ____

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Name of Physician (please print):____

(If authorization is signed by a Physician Assistant or Nurse Practitioner, the name of the supervising physician must be indicated).

Signature: _______________________________________ Date: ________________________

Stamp: Phone: _____________________