

MINNESAUKE ELEMENTARY SCHOOL PRE-KINDERGARTEN REGISTRATION

INSTRUCTION SHEET

Kindergarten registration will be held for both you and your child at Minnesauke Elementary School. Registration and screening procedures will take approximately one hour. **Please do not bring other children to the screening.** We do not have enough room or supervision for them. We are also trying to keep a quiet, comfortable atmosphere. Your help is greatly appreciated.

Parking – Please park in the rear of the building or along the west end of the main parking lot. The large middle area of the parking lot must remain free for arrival and dismissal of school buses.

Personnel assisting in the registration and screening process will wear name tags.

Procedures:

- a) When you arrive, please check in with a PTA volunteer. He/she will check that you have brought all the necessary paperwork and call you for the next step.
- b) You and your child will then meet with Mrs. Kelly McCabe, our psychologist, or Ms. Laura Jankowski, our social worker. At this station, you will be discussing your child's growth and development. Your child will then be escorted to a series of play-type activities comprising our screening process. You will at the same time be meeting with the school secretary, Mrs. Koch, for registration, and with the school nurse, Mrs. Weiner, for health and medical forms.

When these visits are completed, please sit by the exit to wait for your child to finish the screening process. It is expected that your child will go through the screening alone, however you will be nearby.

Questions and Inquiries:

- a) Questions about development, ability or readiness for school should be directed to Mrs. McCabe or Ms. Jankowski.
- b) Questions about health forms or health services should be directed to Mrs. Weiner.
- c) General questions about school information may be asked when you submit your registration papers to Mrs. Koch.
- d) Questions not covered may be submitted with your registration forms. Mrs. Bienia, principal, or Mrs. Essinfeld, assistant principal, will be in touch with you to answer your questions.

Screening Results: You will receive a summary of your child's screening results in the mail approximately a month after the screening. If we have any serious concerns we will contact you sooner. Most children do very well and enjoy the screening activities. Parents who wish to discuss the results of their child's screening may do so by contacting Mrs. McCabe at 730-4214.

June Orientation: On June 6th @ 9:30 a.m., we will host an Orientation for parents and incoming Kindergarten students. At that time, students will visit a Kindergarten classroom and participate in a very short bus ride. Our experience tells us that children greatly enjoy the visit and bus ride. Parents will meet with the building administrators in the auditorium.

THREE VILLAGE CENTRAL SCHOOL DISTRICT

100 Suffolk Avenue Stony Brook, New York 11790

Dear Parents:

In order to help ensure a successful initial school experience for your child, it is important to know something of your child's development and preschool experiences and any special concerns or considerations you may feel are important to share. Please complete the following and return it at your child's kindergarten registration.

Kindergarten Social Development History

Child's name: _____ Birth date: _____ Age: _____

Home address: _____ Home phone: _____

Parent Name: _____ Age: _____ Education: _____

Employment: _____ Phone: _____

Parent Name: _____ Age: _____ Education: _____

Employment: _____ Phone: _____

Child lives with: mother, father, stepfather, stepmother (circle all that apply)

Stepparent's Name: _____ Age: _____ Education: _____

Employment: _____ Phone: _____

Stepparent's name: _____ Age: _____ Education: _____

Employment: _____ Phone: _____

If parents are divorced, please indicate who has custody of the child:

Custody Instructions:

Custodial Parent Name _____ Phone# _____

Court Documentation YES / NO

Children living inside the home:

Name, grade, age and school: _____

Name, grade, age and school: _____

Name, grade, age and school: _____

Name, grade, age and school: _____

Other children living outside the home:

Name and age:

Name and age: _____

Other persons living in the home: _____

Check if child is: Foster child _____ Adopted _____ Age when placed: _____

Birth and Infancy

A. Prenatal and Birth:

1. Mother's general health during pregnancy: _____
2. Labor and delivery: Normal _____ Complications _____
3. Specify any complications during pregnancy, labor and/or delivery: _____

4. Birth weight: _____
5. Infant's days in hospital: _____

B. Infancy:

1. Check one: **Early** **Average** **Later than peers**

Age of sitting	_____	_____	_____
Age of crawling	_____	_____	_____
Age of walking	_____	_____	_____
Using single words	_____	_____	_____
Using sentences	_____	_____	_____
Toilet training	_____	_____	_____

2. Please specify any concerns regarding your child's development: _____

Health History

1. Has your child had any serious illnesses, accidents, operations or hospitalizations?

Yes _____ No _____ If so, please describe: _____

2. Is your child taking medication on a regular basis? Yes _____ No _____

If so, please describe:

3. Please check any particular health problems your child has:

_____ Allergies	_____ Asthma	_____ Earaches
_____ Faulty elimination	_____ Headaches	_____ Nosebleeds
_____ Repeated colds	_____ Sinus trouble	_____ Stomachaches
_____ Other, please describe		

Speech and Language History

1. Can you understand your child's speech?

All/most of the time _____ Some of the time _____ Little of the time _____

2. Can others understand your child's speech?

All/most of the time _____ Some of the time _____ Little of the time _____

3. What is the primary language spoken in your home? _____

4. Are any other languages spoken in your home? Yes _____ No _____

If so, please list:

5. Uses language effectively to communicate with peers, adults? Yes _____ No _____

6. Maintains eye contact during conversation? Yes _____ No _____

Hearing and Vision History

1. Has your child's hearing ever been checked? Yes ____ No _____
If so, where? _____ Date of last exam: _____
Results: _____
2. Do you have any concerns regarding your child's hearing? Yes _____ No _____
If so, please describe _____
3. Has your child had a lot of ear infections? Yes ____ No ____ At what ages? _____
4. Has your child's vision ever been checked? Yes ____ No _____
If so, where? _____ Date of last exam: _____
Results: _____
5. Do you have any concerns regarding your child's vision? Yes ____ No _____
If so, please describe: _____
6. Does your child have listening or attentional problems (e.g., easily distracted short attention span, darts from one activity to another)? Yes ____ No ____
If so, please describe: _____

General Information

1. How many different places has your child lived? _____
2. Has your child attended preschool? Yes ____ No _____
If so, where and when _____
How did your child respond to this experience? _____
3. Are there any illnesses or special circumstances in the home which affect your child?
Yes ___ No ____ If so, please describe _____
4. Have there been any changes in your child's life that may have been stressful or upsetting?
Yes ____ No ____ If so, please describe _____
5. Does your child have any nervous habits or special fears? Yes ____ No ____
If so, please describe _____
6. Do you feel your child is shy? Yes ____ No _____
7. Has your child received any educational support services?
(e.g. special education/OT/PT/speech/language)? Yes ____ No ____
If so, please describe _____

8. What are your child's favorite activities and interests? _____

9. What does your child do that causes him/her to be disciplined most often? _____

10. What is the most effective discipline for your child? _____

11. Compared with other children his/her age, how well does your child:

	<u>Not As Well</u>	<u>About the Same</u>	<u>Better</u>
Get along with siblings?	_____	_____	_____
Get along with friends?	_____	_____	_____
Behave with parents?	_____	_____	_____
Play alone?	_____	_____	_____
Play with others?	_____	_____	_____

12. What is your child's attitude toward starting school? _____

13. Please check any areas of concern you have about your child:

- | | | |
|-------------------|---|------------------------------------|
| ____ Eating | ____ Getting along with adults | ____ Bed-wetting |
| ____ Fears | ____ Uses baby talk | ____ Nightmares |
| ____ Sulking | ____ Nervous habits | ____ Whining |
| ____ Speech | ____ Wants to be babied | ____ Nail biting |
| ____ Coordination | ____ Doesn't sleep alone | ____ Destructive |
| ____ Daydreaming | ____ Temper tantrums | ____ Cries easily |
| ____ Fighting | ____ Restless sleeping | ____ Overly neat |
| ____ Teasing | ____ Complains of being sick | ____ Separation difficulty |
| ____ Jealousy | ____ Getting along with other children | ____ Shy in new situations |
| ____ Disobedience | ____ Lack of concern for other children | ____ Reaction to birth of siblings |

14. Please note anything else you think may be helpful in making your child's school experience successful:

Name of person completing form: _____

Date: _____

Relationship to child:

If questionnaire was completed by an interviewer, please sign below:

Interviewer: _____ Date: _____



Home Language Questionnaire (HLQ)

Dear Parent or Guardian:

In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes English. Your assistance in answering these questions is greatly appreciated.

Thank You

TO BE COMPLETED BY SCHOOL PERSONNEL

DISTRICT *Please print or type clearly*

SCHOOL

GRADE

STUDENT NAME

DATE OF BIRTH

STUDENT IDENTIFICATION NUMBER

COUNTRY OF BIRTH / ANCESTRY

NUMBER OF YEARS ENROLLED IN SCHOOL OUTSIDE THE U.S.

NAME/POSITION OF SCHOOL PERSONNEL COMPLETING THIS SECTION

(✓ boxes that apply)

1. What language(s) is spoken in the student's home or residence? English Other _____
specify

2. What language(s) are spoken most of the time to the student, in the home or residence? English Other _____
specify

3. What language(s) does the student understand? English Other _____
specify

4. What language(s) does the student speak? English Other _____
specify

5. What language(s) does the student read? English Other _____ Does Not Read
specify

6. What language(s) does the student write? English Other _____ Does Not Write
specify

7. In your opinion, how well does the student understand, speak, read and write English?

	<i>Very well</i>	<i>Only a little</i>	<i>Not at all</i>
Understands English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speaks English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reads English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writes English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature of Parent/Guardian/Other _____ Date : _____

**Three Village Central School District
Stony Brook, New York 11790**

REGISTRATION FORM

Child's Name _____

Family Name _____ **Address** _____

Mailing Address _____ **Home Phone** _____

Previous Residence _____ **Date moved to Three Village School District** _____

Parent's Name _____ Parent's Birthplace _____ Parent's Occupation _____

Parent's Employer _____ Employer's Address _____ Employer's Phone _____

Parent's Name _____ Parent's Birthplace _____ Parent's Occupation _____

Parent's Employer _____ Employer's Address _____ Employer's Phone _____

Are the parent's listed above residing with child? ___ Yes ___ No. If you answered no, please list the names of the persons residing at the above address and the relationship to the child, also their place of employment, address and phone number.

Languages of home _____

<u>Children's name(s)</u>		<u>Birthplace</u>				<u>Previous School & Address</u>	<u>Present School</u>
<u>Include all children</u>	<u>D.O.B</u>	<u>(State)</u>	<u>Sex</u>	<u>Grade</u>			
_____ (Last)	_____ (First)	_____	_____	_____	_____	_____	_____
_____ (Last)	_____ (First)	_____	_____	_____	_____	_____	_____
_____ (Last)	_____ (First)	_____	_____	_____	_____	_____	_____
_____ (Last)	_____ (First)	_____	_____	_____	_____	_____	_____

Custodial Instructions

Parent's Name _____ Phone # _____ Court Documents Yes / No

Parent's Signature

***** FOR INCOMING KINDERGARTEN STUDENTS*****

THE FOLLOWING INFORMATION IS PAPERWORK THAT NEEDS TO BE COMPLETED BY THE PARENT/GUARDIAN AS WELL; AS YOUR CHILD'S PHYSICIAN. ANY QUESTIONS CAN BE ADDRESSED TO THE SCHOOL NURSE AT YOUR CHILD'S SCREENING DATE.

PARENT / GUARDIAN, PLEASE COMPLETE THE FOLLOWING

HEALTH HISTORY- must be completed and signed and returned at screening

EMERGENCY CONTACT CARD – This temporary sheet must be completed, signed and returned at screening. It must include your home phone number, business, and beeper and/or cell phone numbers. The school must be provided with at least two local neighbors or relatives who will accept the responsibility for your child in the event you cannot be reached. It is your responsibility to notify the health office of any change or addition of information to the card. A hard copy of the emergency contact card will be sent home at the start of the school year for you to complete.

List any additional family and friends that you are authorizing to pick up your child during the school day; as well as dismissal time. Please send in a note to your child's teacher if you are planning to pick him/her up early and give authorization that someone else will be signing out your child.

PLEASE HAVE YOUR CHILD'S DOCTOR COMPLETE THE FOLLOWING FORMS

IMMUNIZATION CERTIFICATE - Please review the enclosed memo from New York State Department of Health regarding the immunizations that are required by the State entrance into school. Proof of the immunizations must be presented at screening. State Law requires the district to exclude students who have incomplete immunizations.

ELEMENTARY PHYSICAL / HEALTH APPRAISAL - New York State Education Law requires a physical examination for all new entrants to the school district which includes the mandatory BMI. The Elementary Physical / Health Appraisal must be signed, stamped and dated by the physician, physician assistant or nurse practitioner.

ADMINISTRATION OF MEDICATION – SUBMIT ONLY if your child requires medication during the school day. The administration of Medication form needs to be filled out by you and your child's physician for each medication and returned to the health office. This applies to both prescription and over the counter medications. The medication, in its original container, must be brought to the health office by a parent or guardian. Medication is not to be carried by your child. According to state law, medication cannot be administered if these requirements are not met.

DENTAL FORM – To be filled out by your child's dentist

In order to achieve a better understanding of the health services, the following is a partial explanation of what we are doing and what you as parents or guardians can do to make our efforts more effective.

FIRST AID:

In case of an injury the nurse will administer first aid. If the injury is severe and a parent cannot be reached, the school will call 911.

SUDDEN ILLNESS:

If a child becomes sick in school, a parent will be called to come to school to take the child home. In the event a parent cannot be reached, the emergency contact people will be called and asked to come for your child.

SCREENING:

Vision and hearing screening, as well as height and weight, will be done during the school year. You will be notified of any problems. Any findings and recommendations by your child's physician should then be reported back to the school health office.

OUTDOORS DRESS:

Children should be dressed appropriately for the weather and expected to be outdoors at recess when the temperature is above twenty degrees and there is no precipitation.

CALLING IN ABSENCES:

Please notify the health / attendance office, when your child is going to be absent from school. For your convenience, our voice mail is on at all times. If you do not call in, you will receive a message requesting that you call us back regarding your child's absence. An absence note to your child's teacher is also required upon their return to school.

**Immunization Requirements for School Entrance and Attendance
NEW YORK STATE DEPARTMENT OF HEALTH BUREAU
OF COMMUNICABLE DISEASE CONTROL IMMUNIZATION PROGRAM**

The following vaccines are required for a child to attend school:

- * 3 doses of diphtheria - containing toxoid (usually administered as DPT, DT or TD).
- * 3 doses of oral polio vaccine (OPV) or enhanced inactivated poliovirus vaccine (IPV).
- * 1 dose of mumps vaccine administered on or after 12 months of age.
- * 1 dose of rubella vaccine administered on or after 12 months of age.
- * 2 doses of measles vaccine, first dose administered on or after 12 months of age and the second dose recommended to be administered at 4 to 6 years of age and required for kindergarten entry.
- * 3 doses of hepatitis B vaccine
- * 1 dose of varicella vaccine, first dose administered on or after 12 months of age or documentation by the physician stating that your child had the disease.

Religious or medical exemptions to these requirements must be submitted in writing for approval to Mrs. Erin Blaney, Director of Health, PE, Recreation and Athletics

*****FOR STUDENTS ENTERING 6TH GRADE**

If your child turns 11 prior to entering 6th grade in September, they must have the Tdap vaccine. Proof of this immunization must be submitted to the health office. If your child turns 11 after September, proof of this immunization must be presented to us upon their birthday.

THREE VILLAGE CENTRAL SCHOOL DISTRICT
ELEMENTARY PHYSICAL / HEALTH APPRAISAL

Name: _____ Gender: M F Date of Birth: _____

School: _____ Teacher: _____ Grade: _____

PHYSICAL EXAM

DATE OF EXAM: _____ ALLERGIES: _____

Height: _____	Weight: _____	Blood Pressure: _____	Resting Pulse: _____
REQUIRED: Body Mass Index : _____	REQUIRED: Weight Status Category (BMI Percentile): <input type="checkbox"/> less than 5 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th <input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher		
REQUIRED: SPECIFY CURRENT DISEASES: <input type="checkbox"/> ASTHMA <input type="checkbox"/> DIABETES TYPE 1 <input type="checkbox"/> DIABETES TYPE 2 <input type="checkbox"/> HYPERLIPIDEMIA <input type="checkbox"/> HYPERTENSION			

AUDIOMETRY MUST INCLUDE VALUES:				AS 500	1000	2000	4000	Hz	
AUDIOMETRY MUST INCLUDE VALUES:				AD 500	1000	2000	4000	Hz	
Vision – <u>Uncorrected</u> :			R	L	Vision – <u>Corrected</u> :			R	L

EXAM ENTIRELY NORMAL

Specify any abnormality: _____

URINALYSIS:

SPEC. GRAV	PRO.	GLUC.	MICRO
------------	------	-------	-------

MEDICAL	NORMAL	ABNORMAL FINDINGS	MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
NEUROLOGICAL			CONCUSSION	DATE:	
EYES / EARS			SCOLIOSIS / SPINE		
NOSE / THROAT			SHOULDER		
HEART / MURMUR			ARM		
LUNGS			HAND		
ABDOMEN			HIP		
GENITALIA			LEG		
SKIN					
HERNIA					
TEETH / MOUTH					

PHYSICAL EDUCATION / PLAYGROUND / CSE CONSIDERATION

- Free from contagions & physically qualified for all physical education, playground, & school activities OR only as checked:
- Specify medical accommodations needed for school: _____
- Restrictions: _____

Provider's Signature: _____ Phone: _____ Fax: _____

Provider's Name/Address: _____ Stamp: _____

Parent Signature: _____ Parent Phone Number: _____ Date: _____ Rev. _____

THREE VILLAGE CENTRAL SCHOOL DISTRICT IMMUNIZATION CERTIFICATE

Name of Student _____

Date of Birth _____

School _____

Grade _____

For vaccines given in combination, please list each component

DTaP

1	2	3	4	5
---	---	---	---	---

Tdap

--

DT or dT

1	2	3	4	5
---	---	---	---	---

IPV

1	2	3	4	5
---	---	---	---	---

HIB

1	2	3	4
---	---	---	---

VARICELLA

1	2
---	---

Hx of Disease

Month	Year
-------	------

MMR

1	2
---	---

MEASLES

--	--

MUMPS

--	--

RUBELLA

--	--

HEPATITIS B

1	2	3
---	---	---

HEPATITIS A

1	2
---	---

GARDASIL

1	2	3
---	---	---

MENACTRA

--

SIGNATURE OF PHYSICIAN OR CERTIFYING AUTHORITY

DATE

STAMP

Rev 11/08

THREE VILLAGE CENTRAL SCHOOL DISTRICT
SETAUKET, NEW YORK 11733

HEALTH HISTORY

Name of Child _____ Grade _____ Teacher _____
Last First MI

Sex _____ Place of Birth: City _____ State _____ DOB _____

Birth Weight _____ lbs. _____ ozs. Full Term? _____ If premature, # of months _____

Difficulties with birth, please specify: _____

Home Address _____ Phone Number _____

Father's Name _____ Place of Birth: City _____ State _____

Mother's Name _____ Place of Birth: City _____ State _____

=====

Has your child had any of the following illnesses? Please circle the appropriate answer.

Chicken Pox	yes	no
Diphtheria	yes	no
German measles	yes	no
Pneumonia	yes	no
Scarlet Fever	yes	no
Whooping cough	yes	no
Hepatitis A	yes	no
Hepatitis B	yes	no

Please complete the following:

Does your child have allergies to the following?

Food	yes	no
Medication	yes	no
Environment	yes	no
Insect stings	yes	no
Other	yes	no

If so, what are the symptoms and treatment? _____

2. A vision problem? yes no
Wears glasses yes no If yes, full time yes no
Wears contacts yes no If yes, full time yes no
Reading yes no
Board work yes no
Gym/recess yes no

Name of eye care specialist _____

3. A hearing problem yes no
Hearing aide yes no
Had an audiogram yes no

4. Speech difficulty? yes no
Speech therapy yes no
Name of provider _____

5. Understands English? yes no
Speaks English? yes no
If not, primary language _____

Has your child been:

Hospitalized	yes	no
Had Surgery	yes	no

Specify date(s) and reason(s) _____

HEALTH HISTORY

Does your child have any of the following chronic health problems?

DIAGNOSIS	YES	NO	MEDICAL TREATMENT/MEDICATION DURING OR OUTSIDE THE SCHOOL DAY
DIABETES			
TUBERCULOSIS			
SEIZURES (ACTIVE/INACTIVE)			
CYSTIC FIBROSIS			
CEREBRAL PALSY			
ASTHMA			
RESPIRATORY DISORDER			
HEMOPHILLIA			
HEART CONDITION			
HEART MURMUR			
CANCER			
SKIN DISORDER			
HEPATITIS A			
HEPATITIS B			
OTHER			

Does your child:
Experience frequent absences due to illness? _____

Experience frequent hospitalizations? _____

Require special transportation, equipment, precautions in lifting or moving? _____

Other _____

Date _____ Signature of Parent/Guardian _____

Dear Parents/Guardians:

The **Emergency Contact Card** is very important, as we use it to help us carry out your wishes in the event of an emergency during the school day. If a child becomes ill while at school we count on the emergency contact card for information needed to release your child from school. A hard copy will be sent home with your child the first week of school.

Please take time when filling out the card to list all numbers that we can use to reach you including work, cell, and beeper numbers. When noting friends or relatives who can be contacted when we cannot reach you, please make sure the people you list are readily available. The individuals should live locally and know you have listed them to pick your child up and care for him/her in the event of illness.

Occasionally an emergency early dismissal may be necessary. This is usually associated with a weather problem. News of early an closing is posted on the radio. The district calendar lists radio stations to consult. At the beginning of each year it is wise to make emergency plans and discuss them at home.

Thank you for your time and attention to this matter.

EMERGENCY CONTACT CARD FOR ONLY TO BE USED FOR INCOMING KG

Three Village Central School District

Elementary

Student's Name: _____ Birth Date: ____/____/____ Grade: ____ Teacher: _____ Room: ____
(Last Name) First Name mm dd yyyy

Name(s) of Parent or Guardian(s): 1. _____ 2. _____

Address: _____ City/State/Zip: _____ Home Phone: _____

Mother's Cell Phone: _____ Mother's Beeper: _____
Father's Cell Phone: _____ Father's Beeper: _____

Primary e-mail contact: _____ Relationship: _____
Secondary e-mail contact: _____ Relationship: _____

Parent's Place of Employment (please include city):

Mother: _____ Work Phone: _____

Father: _____ Work Place: _____

Step Parent(s): 1. _____ 2. _____

(Name) (Phone number) (Name) (Phone Number)

(Please indicate if step parent is an emergency contact)

If the school cannot contact either parent, please name two local relatives/friends who may be called upon to assume responsibility if child is ill or injured. Transportation of an ill or injured child is to be arranged by parent or persons named below. Please feel free to add additional names to the back of the card. Anyone not listed as an emergency contact will not be permitted to pick up the child.

Name/Relationship: _____ Name/Relationship: _____
Address (Town/Village): _____ Address (Town/Village): _____
Telephone Number(s): _____ Telephone Number(s): _____

Physician to be called in an emergency (local): _____ Telephone Number: _____
Dentist to be called in an emergency (local): _____ Telephone Number: _____
Please list any severe allergy or medical condition(s): _____

Please list any injury or hospitalization (with dates) student has had in the past year: _____

Please list student's current medications: _____

New York State Law requires children entering Kindergarten and new entrants to be examined by their family physician and a report submitted before entering District Schools. Physical exams are also required in grades 2, 4, 7 and 10. It is recommended that this be done by your family physician. Children who do not submit a Physical report will be seen by the school physician.

***The parent/guardian is responsible for notifying the school of any changes in the above stated information.**

Date: _____ Signature of Parent/Guardian: _____

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, whichever 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,

Erin Blaney
Executive Director of Health & Physical Education

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: _____

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

Other Recommendations: _____

=====

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: _____

Address: _____ Phone: _____