Cardinal O'Hara HS

Ph. 716-695-2600 ext 317** FAX 716-692-8697

Note to Health Care Provider/Dentist

Your cooperation is requested to help us care for your patient and to comply with School Health Service Medication Guidelines mandated by New York State.

Please make every effort to recommend administration of medication, particularly controlled substances, outside the school setting. Should you decide to make administration to be during school hours, we will comply with your written instructions.

To Whom It May Concern:

The student: _____
(Name of Student)

Who attends: Cardinal O'Hara high school 39 O'Hara Drive,Tonawanda NY 1415010
(School)

Is receiving: _____
(Medication)

For the treatment of: _____
(Disease)

For the period of: _____ School year_____

And should receive: _____ at _____
Dose…. (Medication) (Times)

Possible side effects: _____
(Side effects)

_____ _____
Date **Signature of Health Care Provider**

_____ _____
Telephone **Print name of Health Care Provider**

Note to Parent/Guardian:

1. Present this completed form to your child's school nurse with your signature authorizing the approval of your Health Care Provider's orders to administer the above medication to your child at school and school-related activities during the regular school hours.

2. To ensure the safety of your child and others, **do not send the medication to school with your child. Bring the medication in the *original labeled container.*** (This applies to prescription and/or over-the counter medications.)

I have read my health care provider's instructions and request that the school nurse comply with these orders.

_____ _____
Date **Parent/Guardian Signature**