



**Millcreek Township School District**  
3740 West 26<sup>th</sup> Street  
Erie, PA 16506  
(814) - 835 - 5300

## **Medication Guidelines Policy 210**

for medication to be taken during school hours  
Students K - 12  
Version: *January 2016*

### **THE FOLLOWING ARE EXCERPTS FROM POLICY 210 - USE OF MEDICATIONS / ASTHMA INHALERS / EPINEPHRINE AUTOINJECTORS**

Medication refers to prescribed and over the counter medications. If at all possible, medication should be administered at home. Medications will be administered during school hours only when failure to take such medicine would jeopardize the health of a student and he/she would not be able to attend school if the medication were not made available. All medications are dispensed from the health room. Students are not to carry medication with them during school hours, nor are they permitted to transport medication to and from school.

In order for medication(s) to be dispensed to students, the following requirements must be met:

#### **For All Medications:**

- ✓ MTSD must receive authorization from the physician AND parent/guardian stating what the medication is, what it is for, the dosage, and the time it is to be given.
- ✓ MTSD must receive the medication in a current, properly labeled prescription bottle. Over the counter medication must be in the original container.
- ✓ Each change in medication (dosage, time or type) throughout the year requires a new authorization form signed by both parent/guardian and physician.
- ✓ Forms must be renewed annually.
- ✓ Student must be responsible to report to the health room to receive their medication at the proper time.

#### **Important Notice about Medications for Field Trips**

If your student is going on a field trip, please make arrangements with your physician for him/her to miss that dose of medication or change the dosage time. If skipping the dose or changing the dosage time is not possible, put the dose in a properly labeled prescription bottle with the student's name, name of medication, and the time it is to be given. **This may require the acquisition of an additional prescription bottle from your pharmacy for field trip purposes. The medication must be brought to school by an adult and given to the nurse.** The nurse is unable to take a dose from your child's supply at school to send on the field trip, as this is against the scope of nursing practice. Call your school nurse if you have any questions or need assistance.



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**Authorization for Medication**  
 Policy 210  
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**COMPLETED BY PARENT OR GUARDIAN (an individual form must be completed for each medication) Section A**

I request that my child, \_\_\_\_\_ Grade \_\_\_\_\_ Homeroom: \_\_\_\_\_ be assisted in taking medications described below at school by authorized persons. I understand that I am responsible for submitting the medication in a proper and timely manner and that, if necessary, the school may request additional information from the physician regarding this medication. I agree to abide by the regulations defined in district policy and I understand that this form must be renewed annually and anytime there is a change in drug, time or dosage.

I agree to waive the School District, their officers, representatives and employees from any and all liability, claims, demands, and causes of action arising out of or in any way connected with the giving of the prescribed medication or treatment. The undersigned parent or guardian hereby assumes all risks of injury or damage to the minor child receiving prescribed medication or treatment during school activities, and specifically waives any claim for acts of negligence by employees of the School District.

Furthermore, as parent or guardian of the minor child to receive prescribed medication and/or treatment, the undersigned hereby expressly agrees to indemnify and forever hold harmless the Millcreek Township School District, officers, and their employees against any loss or any claims, demands, causes of action that might be brought by the minor or in his/her behalf to defray damages incurred by the taking of the prescribed medication and/or treatment given by the School District during regularly scheduled school hours or activities in the School District. As parent or guardian, I hereby waive all exemption rights under all state laws against any claims for reimbursements or indemnification.

**COMPLETED BY PARENT OR GUARDIAN Section A**

<b>Name of Medication:</b>	<b>Parent/Guardian Daytime Phone:</b>
<b>Diagnosis (reason) for which medication is given:</b>	
<b>Dosage:</b>	<b>Time to be Administered:</b>

**Parent / Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**COMPLETED BY LICENSED PHYSICIAN Section B**

<b>Name of Medication:</b>	
<b>Diagnosis (reason) for which medication is given:</b>	
<b>Dosage:</b>	<b>Time to be Administered:</b>
Can time be adjusted to accommodate class ?    Yes    No	
If time to be administered can be adjusted to fit schedule, by how much?	Can dose be omitted for field trips?    Yes    No
If medication is to be given PRN, describe indications and intervals:	
Describe any significant side effects:	
Other information:	
<b>This authorization will be valid for one calendar year from physician's authorization date.</b>	
Is it medically necessary for the student to carry his/her inhaler/epinephrine at all times?	Yes    No
Is this student qualified and able to self-administer his/her inhaler/epinephrine?	Yes    No

**Physician's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_