Clairton City School District

School Health Services
501 Waddell Avenue
Clairton, PA 15025
(412) 233-9200 ext. 1124
Fax: (412) 233-4590

**Student _____ Birthdate _____ Grade/Homeroom_____**

In accordance with school policy, medication(s) should be given at home before and/or after school. When this is not possible, prior to receiving the medication at school, each student must provide the school nurse with a **Medication Administration Consent Form** signed by the parent/guardian and a **Medication Order** from a licensed physician, dentist, CRNP or PA. ***Prescription medication must be in the original prescription container from a pharmacy. Over the counter medications must be sent in the manufacturer's original container.***

## Parental Directive for Administration of Medication

I, the parent/guardian of _____ (student), have provided the school with the necessary forms from my child's doctor to have the medication administered during the school day or on a school sponsored field trip. I understand that the Clairton City School District makes every effort to ensure that only licensed health care professionals administer the medications at school.

However, I also acknowledge and understand that from time to time a licensed health care worker may not be available for the purposes of administering or overseeing the dispensing of medication to my child. In such event (check only **ONE** choice below),

_____ I request, direct and authorize the Clairton City School District to use another school employee or agent to administer the medication.

_____ I do not want the medication administered to the student.

I hereby release, discharge and hold harmless the School District, its agents and employees, from liability for any act or omission committed in connection with administration of my child's prescribed medication.

**Parent/Guardian Signature: _____ Date: _____**

*For Inhaler, Epinephrine auto-injector, Insulin, or emergency medications only: I give permission for my child to carry and self-administer the emergency medication in school and on field trips as directed by the Licensed Prescriber on the reverse side of this form*. I acknowledge that the School District is not responsible for ensuring that my child's self-administered medication is taken.

**Parent/Guardian Signature: _____ Date: _____**

**Print Parent/Guardian Name _____Phone _____**

**THE DOCTOR/HEALTH CARE PROVIDER MUST COMPLETE THE SECTION ON THE REVERSE SIDE.**

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## THIS SECTION MUST BE COMPLETED BY THE HEALTH CARE PROVIDER

Child's Name: _____ D.O.B. _____

Medication: _____Dose: _____

Time & Frequency: _____ Route: _____

Give Daily? Yes _____ No_____ P.R.N. Indications: _____

D/C Date (limit one school year): _____

Allergies: _____

Precautions: _____

**Inhaler:** The child was instructed and is able to demonstrate correct inhaler use. He or she is responsible to carry the inhaler for independent self-administration. ◯ Yes ◯ No

**Epinephrine auto-injector**: The child was instructed and is able to demonstrate correct Epinephrine auto-injector use. He or she is responsible to carry the auto-injector for independent self-admiminstration. ◯ Yes ◯ No

**Give Epinephrine auto-injector immediately after ingestion of allergen or bee sting?**

◯ Yes ◯ No

If NO: List symptoms for Antihistamine: _____

List symptoms for Epinephrine auto-injector: _____

**Insulin**: The child was instructed and is able to demonstrate correct insulin use. He or she is responsible for independent self-administration of insulin. ◯ Yes ◯ No

Health Care Provider Signature _____ Date _____

Print Health Care Provider Name _____ Phone _____