MONTROSE AREA SCHOOL DISTRICT

Junior-Senior High School
75 Meteor Way
Montrose, PA 18801
570-278-3731 Phone
570-278-2873 Fax

Lathrop St. Elementary
130 Lathrop Street
Montrose, PA 18801
570-278-0310 Phone
570-278-1871 Fax

Choconut Valley Elementary
4458 Stanley Lake Road
Friendsville, PA 18818
570-278-7300 Phone
570-553-2738 Fax

MEDICATION FORM

Parents/Guardians are advised to give medications at home on a schedule other than during school hours if possible.

If it is necessary that a medication be given during school hours, the following regulations must be followed.

1. Medication must be brought to school by Parent/Guardian in the original container with appropriate label intact. IF MEDICATION IS NOT PROPERLY LABELED, IT WILL NOT BE ADMINISTERED. Medication will be kept in a locked area in the school.
2. The medication is to be furnished by Parent/Guardian and it is understood that the school does not assume any responsibility for self-administered medications.

PARENT/GUARDIAN SECTION FOR PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS

The school nurse has my permission to:

Administer medication to my child_____ Birthdate____/____/____
Name of medication: _____
Reason for medication: _____
Dosage (amount to be given): _____
Dates/Time medication to be given: _____
I give permission for the school nurse to contact the physician/dentist if necessary.
Parent/Guardian Signature: _____ **Date**____/____/____
Home phone: _____ Work phone: _____

PHYSICIAN SECTION MUST BE SIGNED

Physician's Signature: _____ **Date**____/____/____
Physician's Printed Name:_____ Phone _____
Physician's address:_____
If there are potentially serious side effects, please outline any necessary emergency response on a separate sheet.

FOR SELF-ADMINISTERED INHALED MEDICATION OR EPI-PENS

I have instructed _____in the proper way to use his/her medications, It is my professional opinion that he/she **SHOULD ( )** or **SHOULD NOT ( )** carry his/her inhaler or EPI-PEN by him/herself.
Physician's Signature _____ **Date**____/____/____

I _____ acknowledge that _____ as demonstrated the ability to appropriately carry and self-administer his/her/asthma inhaler and/or epinephrine auto injector.

Nurse's Signature _____ **Date**____/____/____

I _____ acknowledge that I have received instruction from my Certified Health Care provider on proper safety precautions for handling and disposal of the asthma inhaler and/or epinephrine auto-injector, including acknowledgement that I, the student will not allow other students to have access to the prescribed medication and that I understand appropriate safeguards.

Student Signature _____ **Date**____/____/____