Conewago Valley School District
130 Berlin Road, New Oxford, PA 17350 (717)624-2157

Medication Permission Form (Physician Signature Required)

It is the practice of the Conewago Valley School District to request that medication be given before or after school hours whenever possible. If it is essential that the student receive medication during school hours, please complete the following information. No prescribed or over-the-counter medication will be given until this form is completed in entirety and submitted to the school nurse.

Student's Name: ______________________________ **Grade:** _____ **Date of Birth:** _______________
Reason for Medication/Diagnosis: ____
Allergies: ____
List ALL of Current Medications (taken at home and school)**:** ______________________________________
____

**Medication to be Taken at School (if any)				
Name of Medication	Route	Dosage	Time	Possible Side Effects

Asthma Action Plan:

Conditions that Trigger Asthma Symptoms:
____
____
____
____

Steps to Follow for an Acute Asthma Episode:
1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. Use inhaler when peak flow is _______________*

Personal Best Peak Flow Reading: ______________*

(Please Note: A peak flow meter must be brought from home if it is preferred to be measured during school hours)

Student may carry and use his/her own inhaler and knows how to use it. (Please circle) YES NO

Diabetic Orders:

Target Blood Glucose Range:
From_______ **To**_______

Test Ketones When Blood Glucose Is Above: _________

Delay Gym Class When Blood Glucose Is:
Above_________ **or Below**_________

Call Physician When Blood Glucose Is:
Above__________ **or Below**_________

Insulin Orders and/or Insulin Pump Settings:
(Include Insulin type, time and dosage)
____
____
____
____

Sliding Scale Insulin Coverage and Times:
(*During school hours*)
____
____
____
____
____

Additional Instructions:
____
____

Physician's Signature (required) X____
Physician's Phone Number ___________________________________ **Date** ________________________

I give my permission for the school district personnel to administer the aboved medication to my child during school hours. Parent/Guardian's Signature (required) X____

Parents are required to bring the medication to school. Please do not bring the entire supply of medication. The original prescription container is required. Medication left at school will be discarded after a reasonable amount of time.