ADMINISTRATIVE OFFICES • 1301 KAUFFMAN ROAD • POTTSTOWN, PENNSYLVANIA 19464-2398
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PARENT NOTIFICATION OF MEDICATION PROCEDURE

It is our intent to ensure the maximum safety for all students in the Pottsgrove School District. We realize that at times students have medical conditions, which require the use of medication. In most situations, all doses of the prescribed medications can be given at home. However, there are times when it will be necessary for a student to receive medication during school hours. Therefore, the district adopted revised procedural guidelines for medication administration in the schools. These procedures are necessary for compliance with the Pennsylvania State laws including those of the State Board of Nurse Examiners. Please review the following guidelines carefully and consult the nurse in your child's school if you have questions.

When it is necessary for a student to receive ANY medication at school (including over-the-counter drugs, herbal products, essential oils, etc.), your responsibility as parents/guardians will be to do the following:

1. Complete the form "Authorization for School Medication Administration" which includes both PARENT/GUARDIAN and PHYSICIAN signatures. A copy of this form is attached.

   MEDICATION CANNOT BE GIVEN UNTIL WRITTEN PERMISSION IS OBTAINED FROM BOTH PARENT AND PHYSICIAN.

2. Parent/Guardian should HAND DELIVER the medication to the school nurse in the labeled prescription bottle and/or original over-the-counter container. (Upon request, most pharmacists will provide two labeled bottles for a prescription so that one can be brought to school.) If this is not possible, the labeled prescription bottle and/or the original over-the-counter container should be delivered to the nurse in a sealed, labeled envelope.

3. Parent/Guardian should maintain an adequate supply of unexpired medication in the nurse's office throughout the school year.

4. Notify the school nurse in writing with a physician's note and your written instructions if the medication is to be changed or discontinued.

5. Provide the school with a written list of all medication currently being taken by the child.

We appreciate your partnership and cooperation to ensure the health of our students. As always, your inquiries to the school nurse are welcome if clarification is needed.

Sincerely,
AnnMarie Lucas
Director of Pupil Services
Attachment: Authorization for School Medication Administration

POTTSGROVE SCHOOL DISTRICT

AUTHORIZATION FOR MEDICATION ADMINISTRATION

Child's Full Name:_____ Grade_____
Date of Birth: _____ Allergies: _____
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PHYSICIAN REQUEST

NAME of Prescribed Medication: _____

REASON: _____ DOSE: _____

ROUTE: _____ TIME TO BE GIVEN AT SCHOOL : _____

SIDE EFFECTS: _____

MEDICATION IS TO BE ADMINISTERED AS FOLLOWS: (check if applicable)

1. _____ until completed. Last dose: _____
2. _____ entire school year. Daily:_____ PRN_____
3. _____ other_____
4. _____ **INHALERS ONLY** *(Student is able to carry and self-administer during entire school year)*
   _____ **INHALERS ONLY (***Elementary student (K-5) may self administer ONLY at extracurricular activities)*
5. _____ **Asthma Emergency Action Plan needed.** (Physician to provide)

_____ _____
PHYSICIAN SIGNATURE **PRINTED NAME**

_____ _____
DATE **PHONE NUMBER**

****

PARENT REQUEST

I, the parent of _____ request that the employees (nurse, principal or designee) of the Pottsgrove School District administer the above named medication as prescribed by my child's physician. My signature on this document constitutes a complete waiver of liability claim in any and all respects against the Pottsgrove School District and its' Board of Directors and all its' employees unless the District is negligent with regard to any claim for injury in connection with dispensation of the prescribed medication.

Additionally, I agree to provide the medication to the school in the original pharmacy *or manufacturer* labeled container. I also accept responsibility to provide a physician's note and my written instructions if the medication is to be changed or discontinued. I give permission for the school and physician to communicate regarding this medication/medical condition.

_____ _____
DATE **SIGNATURE OF PARENT/GUARDIAN**

Please list all medication currently being taken by child: _____

Revised 06/08