# Mercer Area School District
# Medication Policy and Consent Form

**Mercer Middle/High School**
545 West Butler Street
Mercer, PA 16137
724-662-5104 ext. 21
**724-662-2993 fax**

**Mercer Elementary School**
301 Lamor Road
Mercer, PA 16137
724-662-5102 ext. 3025
**724-662-5103 fax**

Mercer Area School District recognizes that parents have the primary responsibility for administering medication to their children. However, we are aware that at times certain medications must be given while the student is attending school. For the safety of all students, the parent or an adult representing them must bring the medication to school. The medication must be in its original container. A new form must be completed for any change in the medication and also at the beginning of each school year. Medication will be given by the school nurse or her designee under the following conditions:

**Non-prescription**: Medicine will be given only if accompanied by written permission from the parent and from the physician. The medication must be in its original container. The form below must be completed in full and returned to the school nurse.

**Prescriptions**: **Medicine will be given only if needed more than three times a day**. The parent must supply medication for the doses required at school. The medication must be in the original pharmaceutical labeled container. The form below must be completed in full and returned to the school nurse.

Student's Name: _____ Classroom/Teacher: _____

Diagnosis: _____

Medication: _____ Dosage: _____

Time to be administered: _____ Route of Administration: _____

Possible side effects or adverse reactions: _____

Additional medication the student if taking: _____

Inhalers and Epi-pens only: Is the student capable of self-carrying and self-administration? Yes ___ No ___

*The student must demonstrate competency in self-administration and responsibility to carry medication to the certified school nurse before this will be approved. If any misuse or abuse of school policy occurs, privileges will be revoked.*

Physician's signature _____ Date: _____

Physician's name printed: _____

Address _____

Phone: _____

Parent Signature _____ Date: _____