Medication Policy

It is not the responsibility of the Penn Hills School District to administer medications that can be effectively given outside of school hours. Also, first dose of new medications will not be given at school.

All medications must be kept in the Health Room Suite/Nurse's Office. Students are not permitted to carry over-the-counter medications or prescriptions unless special arrangements have been made prior with the Nurse.

THE REVERSE SIDE OF THIS FORM MUST BE COMPLETED AND HAND SIGNED BY "THE PHYSICIAN AND PARENT/GUARDIAN".

I. MEDICATIONS;

1. All medication (**prescription and over the counter**) must be accompanied by a written, signed physician order.

2. Only **"essential"** medication prescribed by a physician and accompanied by written instructions signed by a physician will be given in school. This includes dietary supplements, vitamins, and nutritional products. The written instructions signed by the physician must be separate and apart from the prescription and/or original container.

3. In addition, **a parent or guardian must complete a school medication permission form for each medication.**

4. A new physician order and parent/guardian permission slip must be provided to the school nurse at the beginning of each school year and also with any change in medication or dosage.

5. Original pharmacy labeled container is required.

6. **NO** over-the–counter medications will be distributed unless accompanied by a physician's order.

7. Medications that do not comply with the above regulations will not be given by school personnel and will be returned to the parent/guardian.

8. The school nurse will administer all medications.

II. INJECTABLE MEDICATIONS

1. Medications to be given by injection will be given **ONLY** by the school nurse.

2. Injectable medications must comply with the same regulations required for oral medications.

If a medical condition is severe enough to warrant possession and self-administration, the School District requires specific orders to that effect and release from liability if the student misuses said medication. In such cases, the parent/guardian of the student shall provide a written statement from the treating physician establishing the child's need and competency.

PENN HILLS SCHOOL DISTRICT

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SCHOOL: _____

STUDENT'S LAST NAME: _____ FIRST NAME: _____

SEX: _____ BIRTH DATE: _____ GRADE: _____ ROOM: _____

FOR COMPLETION BY PHYSICIAN/CRNP – SEPARATE AUTHORIZATION FORM REQUIRED FOR EACH MEDICATION

PHYSICIAN / CRNP NAME: _____

TELEPHONE NUMBER: _____

DIAGNOSIS: _____

MEDICATION: _____

FORM/ROUTE: _____

Is the child knowledgeable about his/her medication? _____YES _____ NO

Has the child demonstrated the proper technique in administering medication? _____YES _____NO
Medication is administered DAILY -TIME: _____

Medication is administered when needed. Indications: _____

What is the length of time of treatment? _____

If needed, how soon can administration of medicine be repeated? _____

SIDE EFFECTS: _____

SPECIAL INSTRUCTIONS: _____

PHYSICIAN/CRNP SIGNATURE: _____ DATE: _____
(NO STAMPS or CO-SIGNATURES ACCEPTED)

PHYSICIAN/CRNP PRINTED NAME: _____

FOR COMPLETION BY PARENT / GUARDIAN

PARENT/GUARDIAN NAME: _____

ADDRESS: _____

CELL PHONE: _____ HOME PHONE: _____ WORK PHONE: _____

As the Parent/Guardian of above-named student, I will take full responsibility for transportation of the medication to and from school. I have read the medication policy on the reverse side of this form.

PARENT/GUARDIAN SIGNATURE: _____ RELATIONSHIP: _____

DATE: _____ **(MUST BE IDENTIFIED)**