



MILLVILLE AREA SCHOOL DISTRICT
MILLVILLE, PENNSYLVANIA

REQUEST FORM TO ADMINISTER MEDICATION

TO BE COMPLETED BY PHYSICIAN

_____ must receive the following medication in order to maintain sufficient health to participate in the school program.

NAME OF MEDICATION: _____

DIAGNOSIS WHEN NEEDED: _____

DOSAGE TO BE ADMINISTERED: _____

TIME TO BE ADMINISTERED: _____

LENGTH OF TIME MEDICATION IS TO BE GIVEN:

FROM: _____
(DATE)

TO: _____
(DATE)

PHYSICIAN NAME: _____ PHONE # _____

SIGNATURE OF ATTENDING PHYSICIAN: _____

COMMENTS BY PHYSICIAN: _____

TO BE COMPLETED BY PARENT

I, therefore, request the School District personnel to give my child the above medication. I do hereby release, discharge, and hold harmless the School District and its agents and employees from any and all liability and claim whatsoever for the administration of the above medication to my child, should there develop a reaction from the medication, and/or ensuring that self-administered medication is taken.

PRESCRIPTION NUMBER: _____

DATE ON BOTTLE: _____

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____



MILLVILLE AREA SCHOOL DISTRICT

MEDICATION STATEMENT FOR STUDENTS

The school has a responsibility to cooperate with parents and physicians when it is necessary for students to take medication during the time they are involved in school activities.

In accordance with the recommendations of the Pennsylvania Department of Health, students will be given medication only on the direct written order of a physician. **This includes over-the-counter medications, such as Tylenol and cough medications.**

The parent, guardian, or responsible adult who is acting on behalf of the student, should bring the labeled medication and the properly completed forms to the nurse's office. The school nurse will give the medicine to the student. At the end of the designated time period, which shall be set by the physician, all unused medication will be destroyed, if not picked up by the parents/guardians or designated adult, after notification to the parents or guardians.

The parent or guardian must complete a form before any medicine will be administered. The form, available in the school office, must contain the following information:

1. NAME OF STUDENT
 2. NAME OF MEDICATION
 3. DOSAGE AND TIME MEDICATION IS TO BE GIVEN
 4. SIGNATURE OF PARENT/GUARDIAN
 5. SIGNATURE OF PHYSICIAN
 6. THE PRESCRIPTION NUMBER AND DATE MUST BE ON THE BOTTLE LABEL.
- If the above items are not complied with, the nurse will refuse to honor the request to dispense the medication.
 - It is anticipated that administering medication during school hours will be the exception rather than the rule.
 - For your convenience, completed physician orders that are faxed will be accepted. Our fax number is 570-458-4715 at the Elementary Building and 570-458-5583 at the High School.