MILLVILLE AREA SCHOOL DISTRICT

MILLVILLE, PENNSYLVANIA

REQUEST FORM TO ADMINISTER MEDICATION

Whenever possible, medication should be taken at home. The administration of prescribed medication to a student during school hours will be permitted only when failure to take such medication would jeopardize the health of the student and/or the student would not be able to attend school if the medication was not made available during school hours. **This form is to be completed to implement self-medication for students in grades K-12 who need an inhaler, diabetic supplies, or an EPI-PEN for allergic emergency.** To self-medicate, a student must demonstrate that they are capable and will be responsible.

If a student shares for free or for payment any of his/her medication, it will be dealt with as a violation of the Millville Area School District Drug and Alcohol Policy. The student will receive appropriate consequences and no longer be permitted to self-medicate.

TO BE COMPLETED BY PARENT/GUARDIAN:

Student's Name_____ Date of Birth_____ Grade_____

I hereby authorize the Millville Area School District to permit my student (name above) to self-medication, as indicated in the physician's order below and as indicated in my authorization below.

My student is permitted to take _____ at his/her discretion at school.
Name of Medication

I hereby release Millville Area School District and all of its employees of and from any and all liability in law for damages either I or my student may suffer as a result of this authorization. I give my permission for the school nurse to exchange information with my student's physician regarding this medication.

_____ _____ _____

Parent/Guardian Signature Phone Number Date

TO BE COMPLETED BY PHYSICIAN:

Notice: When possible, the school district urges physicians to schedule medications so that it can be taken at home under the supervision of parents/guardians. The school district will permit self-medication during school hours only when failure to take such medication would jeopardize the health of the student or if the student would not be able to attend school without taking the medication. Physicians are reminded "self-medication" means that the student will take medication at his/her own discretion without intervention of the certified school nurse or licensed healthcare provider.

IT IS NECESSARY THAT (Student's name) _____ RECEIVE THE FOLLOWING MEDICATION AT THE TIMES STATED BELOW:

_____ _____ _____

Name of Medication Dosage Times to be taken

Route of Administration_____

Student may self-administer: ( ) YES ( ) NO Other Specific Directions _____

Purpose of Medication and/or Diagnosis _____

Possible Side Effects _____

Duration of Order _____

_____ _____ _____ _____

Physician (Please Print) Physician Signature Phone Number Date

☐ Student has demonstrated proper self-administration of this medication