Medication Permission Form

Both prescriptions and over the counter medications are sometimes needed for students to take during the school day. At Pequea Valley, we would like to administer these medications in the safest, most efficient and accurate manner abiding by the guidelines set by the PA Department of Health and the Nurse Practice Act. As the parent/guardian, we rely on your assistance to achieve this. Please follow the steps below if your child needs medication in school.

1. Complete the Medication Permission form below. **Note that both parent and MD signatures are required before medication can be given.** Your physician may fax the school approval form if that is more convenient. Fax numbers are as follows: PVHS 717-768-5523; PVIS 717-768-5656; Paradise 717-768-5654; Salisbury 717-442-9741.
2. To protect the student and other students, medications may not be kept with or transported by students. Every medication must be brought to school by a parent/guardian and brought to the health room immediately on entry to the building.
3. Medications are to be brought to school in the original, labeled container as dispensed by the pharmacist or physician.
4. During a field trip, the medications that can be sent are the Emergency Medications of EpiPens and inhalers. If other medications are required during field trips, please talk with your building school nurse.

Parent/Guardian Consent:

I hereby request and give my permission for my child, _____, to receive the following medication, ordered by my health care provider, during the school day. I understand that should a change occur in any of the information, a revised written physician's statement must be provided. I give permission to the school district to share this information about my child's health to help improve the health and safety of my child. Per school policy, the school is not responsible for ensuring the medication is taken and relieving the district and its employees of responsibility for the benefits or consequences of the prescribed medication. I am allowing the school nurse and my physical to communicate regarding this issue.

Parent/Guardian Signature _____ Date _____

Physician Medication Order

Student's Name: _____ Date: _____

Name of Medication: _____ Route and Dosage: _____

Time of Administration: _____ Discontinuation Date: _____

Reason for Medication: _____

Special Considerations and/or Side Effects: _____

Physician Signature: _____ Phone: _____

Physician Name Printed: _____ Fax: _____

11/2013