



Student Name: _____ Grade/Teacher: _____
Date of Birth: _____

Medication Policy and Procedures

This communication is to establish guidelines for children who must take medication while at school. Prescription medication can be given daily by complying with the following policies and procedures:

- 1) Furnish a written authorization from the child's physician and parent or guardian. (Medical Authorization Forms are available at your child's school).
- 2) Send only those prescription medications which **MUST** be given during school hours. (Medications taken three times per day should be given before and after school).
- 3) **IMPORTANT:** Medication should be sent in the original prescription container.
- 4) Parent/guardian **MUST** bring the medication to the school office.
- 5) **DO NOT** send medication with your child on the school bus.
- 6) Medication will be prohibited in desk, lockers or to be carried by the student during the school day. The only exception is an Inhaler with the physician's authorization.
- 7) The child is to go to the nurse's office and request his/her medication at the scheduled time.
- 8) When the physician is not available for consultation, the parent is to assume the complete responsibility for giving any medication to their child while in school.
- 9) Over the counter medications **WILL NOT** be given at school without a doctor's authorization and brought to school in the original container by the parent or guardian.
- 10) If your child has been diagnosed with Asthma, please see the school nurse.

Your cooperation is necessary for the safety of all children and clarification of policy for school personnel. Failure to comply with all guidelines will prevent the school personnel from handling your child's medication.

I have read and understand the above policy and procedure.

Parent/Guardian Signature

Date

_____ School Year

Grade _____

Central Greene School District

WCES Fax: 724-852-1160

MBM Fax: 724-627-0637

WCHS Fax: 724-852-2090

AUTHORIZATION FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS

The following is to be completed by the PARENT:

Child's Name _____ Sex _____ Date of Birth _____

Physician's Name _____ Phone _____

I request that my child be assisted in taking the medicine(s) described below at school by authorized persons or permitted to medicate him/herself as also authorized by me and my physician (see below).

Parent's Name _____ Signature _____ Date _____

Phone _____ Emergency Phone _____ Other _____

The following is to be completed by the PHYSICIAN:

Diagnosis for which medication is given: _____

Name of Medicine:		
Form:		
Dose:		
If medication is to be given DAILY , at what time?		
If medication is to be given WHEN NEEDED , describe indications:		
How soon can it be repeated:		
Is child authorized to medicate him/herself?		
List significant side effects:		
Length of time this treatment is recommended:		
Physician's Name	Physician's Signature	Date

WHEN ANY MEDICATION IS NO LONGER NEEDED, THE UNUSED MEDICATION MUST BE PICKED UP BY THE PARENT/GUARDIAN WITHIN ONE (1) DAY OF THE END OF THE SCHOOL YEAR OR IT WILL BE DISPOSED OF PROPERLY BY THE SCHOOL NURSE.