STATE COLLEGE AREA SCHOOL DISTRICT
STUDENT SERVICES HEALTH SERVICES
PARENTAL REQUEST AND PHYSICIAN'S ORDER FOR MEDICATION
(For students who require medication during school hours)

If possible, medication should be taken at home. The administration of prescribed medication and over the counter 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 medicine were not made available during school hours.**

This form is to be completed to implement the storage, dispensing, student supervision or administration of any medication. The district medication procedure more fully describes the objectives and provisions. A copy of those procedures can be obtained from Student Services (231-1054).

The certified school nurse or licensed healthcare provider stores the medication in the original/prescription labeled container, in a secure place for the period indicated on the physician's order. **Parents/guardians are requested to deliver medication to the school.** All medications shall be picked up at the end of the school year or the end of the period of medication administration. Medications not picked up at the end of the school year will be destroyed.

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TO BE COMPLETED BY PARENT/GUARDIAN:

Student's Name_____ Birth date_____ School_____ Grade _____

I hereby authorize that a prescribed medication be stored for and administered to my student (name above) as indicated in the physician's order below. The medication will be administered by the certified school nurse or licensed healthcare provider. I hereby release the State College Area School District and all of its employees of and from any and all liability in law for damages either my child or I may suffer as a result of this authorization. I give my permission for the school nurse to exchange information with the physician regarding this medication.

_____	_____	_____	_____
Parent/Guardian Signature	Home Phone	Work Phone	Date

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TO BE COMPLETED BY PHYSICIAN:

Notice: The school district urges physicians to schedule medication whenever possible so that it can be taken at home under the supervision of the parents/guardians. The certified school nurse or licensed healthcare provider will supervise students taking medication or administer the medication if failure to take such medication during school hours would jeopardize the health of the student and/or the student would not be able to attend school without it.

IT IS NECESSARY THAT (Student's name)_____RECEIVE THE FOLLOWING MEDICATION AT THE TIMES STATED BELOW. PLEASE STORE AND ADMINISTER THE FOLLOWING AS DIRECTED BELOW:

_____	_____	_____
Name of Medication	Dosage	Times to be taken

Route of Adminstration_____

Student may administer: [ ] Yes [ ] No Other Specific Directions_____

Purpose of Medication and/or Diagnosis _____

Side Effects to Watch For_____

Duration of Order_____

_____	_____	_____	_____
Physician (Please Print)	Physician's Signature	Telephone Number	Date