Seneca Valley School District

Tracy L. Vitale, Ed.D.
Superintendent of Schools

Administration Center
124 Seneca School Road
Harmony, PA 16037-9134
PHONE: (724) 452-6040
FAX: (724) 452-6105

Private Physician Request for Medication Administration in School

Student Name: _____ Grade: _____ Room: ___

1. Medication: _____ Dose: _____
   Time of Administration: _____ Length of Administration: _____
   Reasons for Administration: _____
   Side Effects: _____

2. Medication: _____ Dose: _____
   Time of Administration: _____ Length of Administration: _____
   Reasons for Administration: _____
   Side Effects: _____

3. Medication: _____ Dose: _____
   Time of Administration: _____ Length of Administration: _____
   Reasons for Administration: _____
   Side Effects: _____

Field Trip	**Please choose an option below for Field Trips (required):** **____ The prescribed dose can be withheld on the day of the field trip.** **____ The time can be adjusted with the parent /guardian to be administered upon return to school.** **____ This medication must be given to the child at the prescribed time.** **Comments:**

Competency for Self Administration (for inhalers and Epi-pens ONLY)	**I certify that this student has a potentially life- threatening allergy and/or asthma and requires an inhaler or epinephrine auto injector. This student is competent and has been instructed in the proper method of self -administration of:** **_INHALER** **_EPINEPHRINE** **This student may therefore carry and self -administer his/her inhaler and/or auto injecting epinephrine. If the student abuses or ignores district policy, the school can confiscate the inhaler or epinephrine and remove the privileges to carry the mediation.**

Prescriber's Signature: _____ **Date:** _____
(Not Valid without licensed prescriber signature) **Phone:**

Print Prescriber's Name: _____

PARENT/GUARDIAN SIGNATURE ALSO REQUIRED:
I give permission for my child to receive the medication as ordered by the licensed prescriber. I also authorize, as needed, the sharing of information related to my child's health condition and this medication between the school nurse and the licensed prescriber of the medication. I relieve the district of responsibility for the benefits or consequences of the medication and I acknowledge that the district bears no responsibility for ensuring that medication is being taken.

Parent/Guardian Signature: _____ **Date** _____
(Not Valid without signature)

According to Pennsylvania state medication guidelines, medication not picked up by the parent/guardian at the end of the school year will be disposed of. Medications must be picked up on or before the last day of school at Seneca Valley School District - school nurses are not available after that day.

Revised: 1/2017