FAX TO SCHOOL NURSE
610-838-7473

SAUCON VALLEY SCHOOL DISTRICT
MEDICATION DISPENSING INSTRUCTION FORM

To the Physician:

Schools in Pennsylvania may administer medication to a child only under orders of a physician. This applies to both prescription and over-the-counter drugs. Please complete this form if you wish your patient to receive medication during school hours.

Student's Name ____ Grade_______

Medication prescribed ____

Prescribed dosage and frequency ____

Time of day____

Reason for medication ____

Does medication require refrigeration? ____

Precautions ____

Side-effects ____

Is child taking any other medication(s)? ____

Name of other medication(s) ____

It is my understanding that the employees of the Saucon Valley School District charged with the dispensing of medication may rely upon my directions an contained in this form to dispense the medication which I have prescribed for:

Student's Name ____

The authorization shall be in effect from ______________________, 20___ to ________________, 20__. I certify that I am the physician who prescribed the above medication and that the student who is to receive the medication is under my care. I further certify that it is imperative that the medication prescribed be taken during school hours.

Date_______________ Signature of Physician ____

Print Name of Physician____

Address of Physician ____

Phone Number of Physician ____

Emergency Number of Physician ____

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To the Parent: <u>**MEDICATION MUST BE SENT IN ITS ORIGINAL CONTAINER.**</u>

I DO HEREBY RELEASE, DISCHARGE, AND HOLD HARLESS, THE Saucon Valley School District, its agents, and employees from any and all liability and claim of whatsoever nature for the administration of the above medication to my child any for any and all injury resulting there from.

Signature of Parent/Guardian ____Date ____________________

7/08