CONESTOGA VALLEY SCHOOL DISTRICT
2110 HORSESHOE ROAD LANCASTER, PA 17601

PARENTAL REQUEST AND HEALTHCARE PROVIDER'S ORDER FOR MEDICATION
(For students who require daily or emergency medication)

Parents have the primary responsibility for the health of their child. As a general rule, and if at all possible, medication should be taken at home.
If parents wish to delegate some part of their responsibility to the school, the following will apply:

- Parents and healthcare provider will be required to complete the form below.
- School nurse or designee will dispense medication according to the healthcare provider's written orders.
- Labeled medication will be stored in a secure place for the period indicated on the healthcare provider's order. *At the end of school, the parent is expected to pick up unused medication. ***Medication not picked up by the last day of school will be destroyed.***

TO BE COMPLETED BY PARENT/GUARDIAN:

Child's Name ____Birthdate ____________________ School_______________________

I request that medication for my child (named above) be stored or administered as indicated in the healthcare provider's order below. I am aware that non-medical personnel may be administering this medication to my child. We hereby release the Conestoga Valley School District and all of its employees of and from any and all liability in law for damages either we or our child may suffer as a result of this request.

Parent/Guardian Signature____Date________

Home Telephone_______________________________ Work Telephone_________________________

TO BE COMPLETED BY HEALTHCARE PROVIDER:

IT IS NECESSARY THAT THE NAMED CHILD RECEIVE THE FOLLOWING MEDICATION AT THE TIMES STATED BELOW. PLEASE STORE AND ADMINISTER THE FOLLOWING AS DIRECTED BELOW:

Name and Form of Medication:____Dosage:_______________

Time(s) to be given:_____________Route of Administration:______________________________________

Other Specific Directions:____

Purpose of Medication and/or Diagnosis:____

Side Effects to Watch:____

Duration of Order:____

Omit dose of this medication if student goes on a field trip: Yes______ No ______

Student demonstrates capability of using/self-carrying inhaler: Yes ______ No ______

_____________________________ _____________________________ ____________________ _______________

Healthcare Provider's Name Healthcare Provider's Signature Telephone Date

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PERMISSION FOR SELF CARRY OF EPI PEN, INHALER

I recognize that school policy requires all prescription medication to be stored in the nurse's office and to be dispensed only by nurse or designee. Because of the nature of this medication, I request that my child be permitted to carry the medication at all times and to use as directed by the healthcare provider. To be granted such permission, I shall file this completed form with the nurse and I will assume all responsibility for any problems resulting from granting this permission. This responsibility includes, but is not limited to, misuse, loss and/or sharing the medication with others. I also verify that the above student is competent in using his/her inhaler. In addition, I will notify my student that he/she must notify the school nurse immediately following each use of the inhaler.

____ ______________________

Parent Signature Date