

AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS

The Easton Area School District requires a physician's/psychiatrist's/dentist's written order and a parent's/legal guardian's/emancipated student's authorization for the school nurse, or in her/his absence the designee to administer medications. Medications must be in the original medication container. Students with permission to self-administer EpiPen/metered dose inhalers must carry their medication with them at all times, and have it labeled with their name/homeroom.

PHYSICIAN'S/PSYCHIATRIST'S/DENTIST'S ORDER

_____ **STUDENT'S NAME** _____ **GRADE** _____ **DATE OF BIRTH**

The child should receive the following medication during school hours in order to maintain sufficient health and participation in the school program. **CONDITION FOR WHICH MEDICATION IS ADMINISTERED:** _____

MEDICATION: _____

DOSAGE: _____ **TIME:** _____

POSSIBLE SIDE EFFECTS: _____

I HAVE INSTRUCTED _____ IN THE PROPER WAY TO USE HIS/HER (INHALER) (EPIPEN).
_____ IT IS IN MY PROFESSIONAL OPINION THAT HE/SHE MAY BE ALLOWED TO CARRY AND USE THIS
MEDICATION BY HIMSELF/HERSELF WHEN IN SCHOOL. (Initial)

_____ IT IS MY PROFESSIONAL OPINION THAT HE/SHE MAY BE ALLOWED TO CARRY AND USE THIS
MEDICATION DURING SCHOOL-RELATED FIELD TRIPS. (Initial)

IT IS MY PROFESSIONAL OPINION THAT _____ SHOULD NOT CARRY HIS/HER
(INHALER) (EPIPEN) BY HIMSELF/HERSELF.

PHYSICIAN'S/PSYCHIATRIST'S/DENTIST'S NAME – **PRINTED:** _____

ADDRESS: _____ PHONE: _____

SIGNATURE OF PHYSICIAN/PSYCHIATRIST/DENTIST _____ DATE

AUTHORIZATION BY PARENT/LEGAL GUARDIAN/EMANCIPATED STUDENT

I/WE DO HERBY REQUEST THAT _____ receive the above medication during school hours in order to maintain sufficient health and participation in the school program.

OR

I/WE DO HEREBY REQUEST THAT _____ be allowed to carry/self-administer his/her (Inhaler) (EpiPen) as directed per above and do hereby agree to follow the EASD procedures set forth for self-possession/administration. I/We acknowledge that EASD may revoke this privilege for non-compliance with said procedure. I/We accept full responsibility regarding the benefits and consequences of self-possession/administration for this medication.

We (I) do hereby grant permission for school staff to communicate directly with the physician/psychiatrist/dentist named above.

We (I) do hereby release, discharge, and hold harmless EASD, its agents, and employees from any and all liability and claims whatsoever in connection with administration of the above medication to my child and/or by my child.

We (I) have read and agree to follow the procedures set forth by the policy and procedure.

SIGNATURE OF PARENT/LEGAL GUARDIAN/EMANCIPATED STUDENT _____ DATE

Check one: () Parent () Legal Guardian () Emancipated Student

ADDRESS: _____ PHONE: _____

ADULT DESIGNEE: _____

(IF ADULT OTHER THAT PARENT/LEGAL GUARDIAN/EMANCIPATED STUDENT WILL BE DELIVERING
MEDICATION TO THE SCHOOL)

FOR SCHOOL USE ONLY:

DATE RECEIVED: _____ RECEIVED BY: _____

OVER

EASTON AREA SCHOOL DISTRICT
DEPARTMENT OF STUDENT & COMMUNITY SERVICES
1801 BUSHKILL DR., EASTON, PENNSYLVANIA 18040

AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS

Dear Parent/Legal Guardian/Emancipated Student:

Continued concern for the health and safety of your child in the Easton Area School District has prompted a change in the medication distribution policy and procedure. **If your child needs to take medicine in school, prescription or *over-the-counter, the procedure is as follows:**

As a provided service, medication including over-the-counter medication will be administered to students in the regular school setting and only in circumstances when the child's health may be jeopardized without it. **Written authorization**, signed by the physician, psychiatrist, or dentist **and** the parent, legal guardian, or emancipated student must be provided for each separate prescription or medication being administered to each student. If dosage is changed, new written authorization is required. Authorization will terminate with the expiration date of the prescription or at the end of the school year, whichever occurs first. If the medication is discontinued, the parent or legal guardian must notify the school nurse in writing.

Medication must be delivered to the school nurse by the parent, legal guardian, authorized adult designee or emancipated student in the original medication container and in an amount not to exceed a 20-school day supply. Students are not to have medication in their possession at any time per school district drug and alcohol policy (*exception is made for only those students with doctor's authorizations to possess/self-administer Epipens and inhalant medications).

It will be the responsibility of the parent, legal guardian, or emancipated student to make alternative arrangements for administration of medication during activities away from school.

Medication sent to school in violation of this policy will not be administered to a student.

Students who violate protocols for self-possession or self-administration will have the medication confiscated and their self-possession privileges will be revoked.

*Over-the-counter: Does not apply to cough drops or non-aerosol sunscreen, but does include Aspirin, Tylenol, Ibuprofen, and antacids, etc., in which case a one school year standing order from the child's personal physician will be accepted.

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