

MANHEIM CENTRAL SCHOOL DISTRICT HEALTH SERVICES

High School
717-664-8422
Fax 717-664-8420

Middle School
717-664-1705
Fax 717-664-1859

Doe Run Elementary
717-665-8813
Fax 717-665-8819

Baron Elementary
717-665-8904
Fax 717-665-8909

Medication Authorization Form

(To be completed by a Physician, Dentist, CRNP, PA)

The PA State Law and the medication policy of Manheim Central School District requires the written order of a physician/dentist/CRNP/PA's and the written authorization of the parent/guardian for a nurse to administer both over the counter (OTC) or prescription medications. Medications must be in the original container for OTC; or in a properly labeled, pharmacy-prepared container with the name of the student, name of the drug, dosage, method of administration, time of the dose, date of original prescription and the name of the prescribing licensed health care provider.

Name of Student _____ Date _____

Address _____ DOB _____

Condition for which the drug is needed to be administered during school hours _____

Drug (name, dose, and method of administration) _____

Time of administration _____

Date to begin administration at school _____

Relevant side effects to be observed, if any _____

Inhaler is to be kept with student? _____ Yes** _____ No

**Inhalers that are prescribed by a physician may be kept with the student only when this form is completed and returned to the school nurse. The completed form will be retained on file in the health room. A new form must be completed for each school year.

PHYSICIAN SIGNATURE: _____ **Date:** _____

PARENT/GUARDIAN AUTHORIZATION:

I request that the above medication, ordered by the physician/dentist/CRNP/PA for my child _____ be administered by school personnel. I understand that I must supply the school with medication in the original container for OTC; or in a properly labeled, pharmacy-prepared container with the name of the student, name of the drug, dosage, method of administration, time of the dose, date of original prescription and the name of the prescribing licensed health care provider, and I will provide no more than a 45-school day supply. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.

PARENT/GUARDIAN SIGNATURE: _____ **Date:** _____

RELATIONSHIP TO CHILD: _____ **Phone:** _____