

Bermudian Springs School District

7335 Carlisle Pike York Springs PA 17372

(717)-528-4113 (717)-624-4231

Dear Parent:

When it is necessary for your child to receive medication during school hours, the following procedure is required:

1. A written physician's order and parent/guardian consent must be received for each medication every school year. A form is available from the school nurse or school office personnel to be completed.
2. **All** medication must be in the **original** container **labeled** with the student's name, medication name, and dosage. (If necessary, request a duplicate bottle from the pharmacist).
3. Any change in type, dosage, or discontinuance of the medication must be reported to the school nurse immediately.
4. Medication must be brought to school by the parent/guardian or a designated adult. Medications may not be sent to school on the person or property of a student. The parent/guardian or designated adult will be required to sign a form with the school nurse **every time** medication is brought to school, including refills of medications.
5. Please make an appointment with the School Nurse to deliver medications.

All of these requirements must be met before the school will administer any medications.

If the health of the child is substantially impaired when the medication is forgotten or administered early or late, parents/guardians should keep the child at home or be responsible for administering the medication. A parent/guardian or designee is permitted to come to school to administer the medication.

Medications should be scheduled so that they may be given at home, but it is understood that this is not always possible.

If there is a concern regarding this matter, please call your child's school nurse.

Thank you,

School Nurse

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Medication Administration Form

Student's Name _____ Grade _____

Diagnosis _____ Duration of administration _____

Medication Name _____ Dosage _____

Route (oral/drops/injection) _____ Time _____

Side Effects _____

Restriction of specified school activities (sports, shop, driver training)

Other medication(s) student is taking _____

Physician's Name _____ Phone _____
(Please Print)

Physician's Signature _____ Date _____

I request that school personnel administer this prescribed medication. I hereby release Bermudian Springs School District and all its employees from any and all liability for damages my child may suffer as a result of this request.

I understand that the school nurse will contact my child's health care provider to clarify this medication/procedure order if necessary.

Any discontinued medication not removed from the school by a parent/guardian or designated adult within a two-week period will be disposed of by the nurse.

It is the policy of Bermudian Springs School District to administer prescribed medication during school hours only when absolutely necessary.

Prescription medication must be sent to school in a container with the prescription label by a pharmacist. The pharmacist may be asked for a separate, properly labeled container for school use.

The parent/guardian or designated adult bringing the medication to school will be required to sign a form with the school nurse every time medication is brought to school, including refills of medication.

If ANY medication is not in the original container, it WILL NOT be given.

Parent/Guardian Signature _____ Date _____