Peters Township School District

PETERS TOWNSHIP SCHOOL DISTRICT MEDICATION FORM

Dear Parents/Guardian:

The Peters Township School District takes the position that when children are ill, it is best to develop a treatment plan with the consultation of a physician. When possible, the treatment plan should provide for administering medication at times other than during school hours. This can often be accomplished with the use of time-released medication or dispensing medication before or after school hours.

The School District recognizes, however, that there may be instances when medication must be administered during the school day. It will be necessary for parents to provide the School Nurse with parental **AND** physician consent.

Please feel free to contact the School Nurse if you have any concerns regarding this matter. Thank you for your cooperation.

Peters Township School District Health Offices:

Bower Hill Elementary:	724-941-0913 ext. 2403	Fax: 724-941-0918
McMurray Elementary:	724-941-5020 ext. 3006	Fax: 724-941-2769
Pleasant Valley Elementary:	724-941-6260 ext. 1404	Fax: 724-941-0708
Middle School:	724-941-2688 ext. 4255	Fax: 724-942-0915
High School:	724-941-6250 ext. 8010	Fax: 724-941-6703

PETERS TOWNSHIP SCHOOL DISTRICT
MEDICATION FORM

Authorization for Prescription or Non-Prescription Medications to be Taken During School Hours

- Prescription medication must be in a container labeled by the pharmacy.
- Over-the-counter medication must be in the original container.

Parent to Complete this Section**

Student's Name:_____ Date of Birth :_____Sex _____
School Name:_____ Grade/Room/Section: _____
Physician Name:_____ Phone:_____
Address:_____ Parent Emergency Phone:_____

Student Allergies:_____

Current Medications: _____

I fully understand the directions that have been given to the school by the physician and I give my consent for the medication prescribed below by the physician to be administered to my child at school or for the school to monitor the self-administration of the medication by my child. In consideration of the School District's agreement to use good faith efforts to follow the physician's instructions, I hereby release the school and its personnel from any liability associated with the administration of this medication either by School District personnel or by my child.

I understand and agree that any medical information may be shared with appropriate school and medical personnel. I authorize necessary school personnel to contact the medical provider named above regarding this medication and to release information regarding my child (named above) to that provider. I authorize the medical provider to release information to the school regarding my child (named above) and his/her medication(s). I understand that this consent is necessary in order to protect the limited confidentiality of medical information and that this consent is limited for the purpose and to the person or entity listed above and will be effective for the present school year. I understand that the disclosed information will be kept confidential and that disclosing school personnel will not be responsible for the re-disclosure of any such information.

I understand that this consent is revocable with written, or if necessary, verbal notice, except to the extent that action has been taken in reliance thereon.

PARENT/GUARDIAN SIGNATURE:_____ Date_____

PRINT PARENT NAME:_____ Date_____

Student Name: _____

Physician to Complete this Section**			
To be given during school:	**Medication #1**	**Medication #2**	**Medication #3**
Name of Medication:			
Dose/Route:			
Indication/Reason to be given:			
Time/frequency to be given:			
Date to be initiated:			
Date to be discontinued:			
Special Instructions: (e.g. activity restrictions, precautions, etc.)			
Possible Adverse reactions:			
Emergency Response:			

Insulin only:

This student is capable of self-administration: Yes___ No___

Comments:_____

_____

Inhalers & epinephrine auto-injectors only:

This student is capable of self-administration: Yes___ No___

This student may carry his/her inhaler or epinephrine auto-injector on his/her person: Yes___ No___

Comments:_____

_____

COMPLETE THIS SECTION ONLY IF STUDENT SELF-ADMINISTERS INSULIN, ASTHMA INHALER, OR EPINEPHRINE AUTO-INJECTORS:

☐INSULIN- Student acknowledges that s/he has received instruction from their health care practitioner on Proper safety precautions for the handling and disposal of the medications and monitoring equipment. S/He will not allow other students to have access to the medication and monitoring equipment.

☐INHALER/EPINEPHRINE AUTO-INJECTOR - Student acknowledges that s/he has received instruction from their health care practitioner on proper safety precautions for the handling and disposal of asthma inhaler and/or epinephrine auto-injector. S/HE will notify the school nurse immediately following the use of an asthma inhaler or epinephrine auto-injector. S/He will not allow other students to have access to the prescribed medication and understands the safeguards.

STUDENT SIGNATURE: _____ **Date:**_____

The school nurse acknowledges that the student is competent and able to self-administer medication, asthma inhaler, or epinephrine auto-injector and use monitoring equipment.

NURSE SIGNATURE: _____ **Date:** _____

PHYSICIAN SIGNATURE:_____**Date**_____

PRINT PHYSICIAN NAME:_____ **Date**_____

Anytime there are medication changes, this form must be updated by the parent/physician.

Revised October 15, 2021