

MEDICATION ADMINISTRATION FORM FOR STUDENTS

Columbia-Montour Area Vocational Technical School

THIS FORM MUST BE COMPLETED IF A STUDENT NEEDS TO TAKE MEDICATION AT SCHOOL. (Please read details below.)

Students will be given prescription medication or other medications not routinely stocked in the nurse's office **only by the direct written order of a physician**, according to recommendations of the Pennsylvania Department of Health and this school's medication policy. (Regular-strength Tylenol and Ibuprofen and antacids are routinely stocked in the nurse's office and do not require individual students' doctor orders.)

The attached form must be completed by the parent or guardian and the physician before any medicine will be administered. **A new form is needed at the beginning of each school year and for each new medication order.** The form, available from the nurse's office or online on the school's website, must contain the following information: Name of student; Diagnosis or reason for needing the medication; Name of medication; Dosage and time medication is to be given; Signature of parent/guardian; and Signature of physician.

The medication must be in an original bottle which includes the prescription number and date. **ALL MEDICATIONS AND SUPPLIES MUST BE STORED IN THE NURSE'S OFFICE. IT IS A VIOLATION OF SCHOOL POLICY FOR A STUDENT TO CARRY MEDICATIONS ON HIM OR HERSELF WITHOUT A PHYSICIAN'S ORDER ON FILE IN THE NURSE'S OFFICE. THIS INCLUDES, BUT IS NOT LIMITED TO, INHALERS OR EPIPENS UNLESS PROPER ADDITIONAL GUIDELINES ARE FOLLOWED ACCORDING TO THE SCHOOL'S POLICY.**

If a student has a severe allergy that may require an Epi-Pen or Benadryl, the parent must provide the medication to the nurse's office with the necessary paperwork as explained.

The parent, guardian, or a responsible adult who is acting on behalf of the student, should bring the medication and the properly completed medication form to the nurse's office. The medicine will be given to the student by the school nurse or an individual designated by the building administrator. At the end of the designated time period, which shall be set by the physician, all unused medication will be returned to the parent or will be destroyed after notifying the parents or guardian if the medication is not picked up at the school.

If the above information is not complied with, the school employee will refuse to honor the request to dispense the medication to the student. **Carrying medication without complying with the above information can result in disciplinary action.**

It is anticipated that administering medicine during school hours will be the exception when necessary rather than the rule. Medication policies are available at this school for your review.

PLEASE COMPLETE THE ATTACHED FORM AND RETURN IT TO THE NURSE'S OFFICE. MEDICATION CANNOT BE ADMINISTERED WITHOUT IT.

COLUMBIA-MONTOUR AREA VOCATIONAL TECHNICAL SCHOOL

5050 Sweppenheiser Drive, Bloomsburg, PA 17815

PERMISSION TO GIVE / TO KEEP / TO CARRY MEDICATION AT SCHOOL

To be completed each school year and/or when student's medication changes

PARENTS ARE RESPONSIBLE FOR INFORMING THE SCHOOL NURSE OF ANY CHANGES IN MEDICATION, DOSAGE, OR IF THE MEDICATION IS DISCONTINUED.

CHILD'S NAME: _____ GRADE: _____
HOME ADDRESS: _____ PHONE: _____

PHYSICIAN'S PERMISSION (or attach Physician's Statement)

The child named above is being treated by me for (Diagnosis) _____
and must/may take (Medication) _____ Dosage _____
Time ___ noon/lunch For ___ days
___ as needed ___ remainder of the current school year
___ every 4 hrs ___ until medication is discontinued/changed
___ not more than once per day ___ must carry on person
___ other (specify time) _____ ___ other (specify) _____

This child is able to self-administer his/her inhaler: yes / no (please circle one).
Emergency response if dose ineffective: _____

I certify that I am the health care provider who prescribed the medication and that the student named above is my patient for diagnosis and treatment. I understand that the Columbia-Montour Area Vocational Technical School and its employees will be distributing medication; they will be relying upon the directions I have set forth above.

Print/stamp name & phone number below

Signature _____ Date _____
M.D., D.O., P.A., C.R.N.P.

PARENT/GUARDIAN'S PERMISSION

My child must/may take the medication specified above. I, therefore, request the school district personnel to give my child the above medication. I do hereby release, discharge and hold harmless, the school district, its agents and employees, from any and all liability and claim whatsoever for the administration of the above medication to my child should there develop a reaction from the medication.

Signature _____ Date _____

ASTHMA INHALER/EPIPEN USAGE

(Only to be signed if student is to self-carry/self-use asthma inhalers or EpiPen)

I acknowledge that the school is not responsible for ensuring the medication is taken. I also relieve the school and its employees of responsibility for the benefits or consequences of the prescribed medication.

Signature _____ Date _____