ABINGTON SCHOOL DISTRICT

Abington, Pennsylvania

MEDICATION POLICY- MEDICATION PERMISSION FORM

Medication(s) should be given at home before and/or after school. However, when this is not possible, prior to medication being administered to a student during the school day, ***the parent/guardian or responsible adult must personally deliver to the school nurse the following***:

1. Written orders from a qualified health care provider giving the child's diagnosis and the dosage and frequency of its administration for each prescribed medication.
2. Written permission from the parent/guardian for the school to comply with the qualified health care provider's order.
3. An explanation of the reason the medication(s) must be taken during school hours.
4. Medication in its original container properly labeled by the pharmacy or qualified healthcare provider or the over-the-counter medication in its original container as purchased. **One month supply only.**

School personnel may only administer medication prescribed by a qualified healthcare provider.

HEALTH CARE PROVIDER'S AUTHORIZATION
TO BE COMPLETED BY PHYSICIAN

Student's Name_____DOB_____Grade_____

School _____

Diagnosis: _____

Medication 1: _____ Dosage _____ Frequency _____

Possible side effects _____

Restrictions_____

Medication 2: _____ Dosage _____ Frequency _____

Possible side effects _____

Restrictions_____

Reason for medication during school hours: _____

***Inhaler or Epinephrine Auto-Injector*: Student is authorized to carry and self-administer?** Yes_____ No_____

Field Trip*: *Daily Medications only. The medication may need to be omitted or time changed during a field trip. Please Indicate below:

- Omit medication during the field trip: _____
- Time of medication may be changed to: _____

Health Care Provider Name (please print):_____

Health Care Provider Signature (required): _____

Date: _____ Telephone No.:_____

To Be Completed By Parent/Guardian

I (print parent/guardian name) _____ hereby give my consent for my child/student identified above to receive the above medication as prescribed and I release the Abington School District of all responsibility for any benefit and any and all adverse consequences of the medication. I also give consent for Abington School District Health Services Staff to communicate with the above Health Care Provider for the benefit of my child/student. I understand that a new order is needed each school year and that any medications not picked up at the end of the school year will be discarded.

Date_____ **Parent/Guardian Signature** _____