Western Elementary School Ph: 610-797-1688 Fax: 610-797-9641	Harry S. Truman Elementary School Ph: 610-791-2800 Fax: 610-797-9640	Salisbury Middle School Ph: 610-791-0830 Fax: 610-797-9648	Salisbury High School Ph: 610-797-4107 Fax: 610-797-1972

SALISBURY TOWNSHIP SCHOOL DISTRICT
HEALTH SERVICES
AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS

FOR THE PHYSICIAN / LEGAL PRESCRIBER

_____ must receive medication for the following

condition: _____

This medication must be given during school hours in order to achieve sufficient health and well being.

MEDICATION: _____

PRESCRIBED SCHOOL DOSAGE: _____

TIME TO BE ADMINISTERED: _____

DURATION: _____

POSSIBLE SIDE EFFECTS: _____

PHYSICIAN'S SIGNATURE: _____DATE_____

SELF-ADMINISTRATION OF INHALERS, INSULIN or EPIPEN ONLY:
Do you recommend that the student carry and self-administer this medication without direct supervision, if needed? YES _____ NO _____

PHYSICIAN'S SIGNATURE: _____DATE _____

FOR THE PARENT OR GUARDIAN

I authorize the above medication to be administered by the school nurse, authorized personnel of STSD, or my child (if indicated above). I authorize STSD and the above-named prescriber to exchange health-related information regarding the care of my child and the administration of this medication. I agree to deliver the medication to the school health room unless my child has permission to self administer per STSD policy.

PARENT / GUARDIAN SIGNATURE _____ DATE _____

STUDENT'S NAME _____ GRADE/TEACHER _____

SALISBURY TOWNSHIP SCHOOL DISTRICT
HEALTH SERVICES
MEDICATION PROCEDURE

TO: ALL PARENTS/GUARDIANS
FROM: SALISBURY TOWNSHIP SCHOOL DISTRICT NURSES

It is important that you do not send your child's medication to school unless absolutely necessary. If your child is on medication while recovering from an illness, please make every attempt to schedule the administration of medication(s) around the school schedule (e.g. before school, after school, at bedtime). If your child needs medication during school hours or on an "as needed" basis, the form on the back of this letter must be completed. Please note that both the physician/ legal prescriber portion and the parent portion must be completed prior to school personnel dispensing any medication.

IMPORTANT: All medication—except Epipens, asthma inhalers, and diabetic supplies—MUST be delivered to the school nurse by the parent. The prescribed medication must be in a labeled prescription bottle or in an original over the counter bottle. If prescribed, the label must contain the CHILD'S NAME, the NAME of the PRESCRIBED DRUG, the TIME and DOSE to be given, the LEGAL PRESCRIBER'S NAME, and the PHARMACY name. The label on the bottle must match the prescriber's order.

It is your child's responsibility to come to the health room at the appropriate time to receive his/her medication. However, if your child fails to come to the health room, we will make a reasonable attempt to find him / her. The parent/guardian must be aware of the amount of medication in school and deliver a new supply as needed. The nurse will try to notify the parent when refills are needed. At the end of the school year, the parent must pick up any unused medication.

IF THE PRESCRIBED DOSAGE OF MEDICATION CHANGES AT ANY TIME, NEW FORMS MUST BE COMPLETED BY THE PHYSICIAN / PRESCRIBER AND SIGNED BY THE PARENT. AN ORDER FROM THE PRESCRIBER IS ALSO REQUIRED IF THE MEDICINE IS NO LONGER NEEDED.

If you and your physician feel your child has the need and is capable of self-administering his / her inhaler, Epipen, or insulin, your physician must give permission by checking yes under the self-administration section on the back of this form.

THIS ORDER IS VALID FOR ONE SCHOOL YEAR ONLY.

PLEASE COMPLETE BOTH SECTIONS ON THE REVERSE SIDE AND SUBMIT WITH THE MEDICATION TO THE SCHOOL NURSE.