SALISBURY TOWNSHIP SCHOOL DISTRICT

SCHOOL HEALTH SERVICES

TO: ALL PARENTS/GUARDIANS

FROM: SALISBURY TOWNSHIP SCHOOL DISTRICT HEALTH SERVICES

SUBJECT: MEDICATION PROCEDURE

It is important that you do not send your child's medications to school unless absolutely necessary. If your child has recovered from an illness but is still on medication, the administration of medication(s) may be spaced around the school schedule (e.g. before school, after school, at bedtime). If your child has a chronic condition and routinely 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.**

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 all reasonable attempts 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 also try to notify you when refills are needed. IF THE PRESCRIBED DOSAGE OF MEDICATION CHANGES AT ANY TIME, NEW FORMS MUST BE COMPLETED BY THE PARENT AND PHYSICIAN / PRESCRIBER.

IMPORTANT: All medication—except epi-pens and asthma inhalers—MUST be delivered to the school nurse **by the parent.** The prescribed medication must be in a **labeled prescription bottle (or in an original container, if medication is OTC).** 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 parent must retrieve any remaining medication at the end of the school year.

If you and your physician feel your child has the need and is capable of self-administering his / her inhaler or epi-pen, your physician must grant specific permission 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.

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

FOR THE PHYSICIAN / LEGAL PRESCRIBER

_____ must receive medication prescribed by me for the following condition: _____
_____.

This medication must be given during school hours in order to maintain sufficient health and to participate in the school program.

MEDICATION _____
PRESCRIBED SCHOOL DOSAGE _____
TIME TO BE ADMINISTERED _____
DURATION _____
POSSIBLE SIDE EFFECTS _____

PHYSICIAN'S SIGNATURE _____ DATE _____

SELF-ADMINISTRATION OF INHALED MEDICATION or EPI-PEN 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 medication named above 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 it is an asthma inhaler, antibiotic, or OTC medication that my child may deliver to the health room upon arrival to school.

_____ _____
DATE **PARENT / GUARDIAN SIGNATURE**