

HEMPFIELD AREA SCHOOL DISTRICT

PLEASE KEEP THESE FORMS FOR USE THROUGHOUT THE SCHOOL YEAR

Dear Parent/Guardian:

Hempfield Area School District recognizes that there are conditions that necessitate the use of medication, including emergency medication such as an inhaler, an Epipen and/or Benadryl, by students during school hours.

To enable the school district to meet its responsibility to safely assist with the treatment plan requiring administration of medication, there must be compliance with the medication policy and procedures attached to this notice.

The medication and forms must be brought to the school nurse.

If these requirements cannot be met or the parent/guardian elects not to follow these requirements, the medication will not be administered at school. The parent/guardian has the option of then coming to school at the prescribed time and administering the medication.

*** An adult must deliver any medication that is considered a controlled medication, such as Ritalin, Adderall, or Dexedrine (including the generic forms) to the school. The medication delivered to school should not exceed a one-month supply.**

*** If your child must keep emergency medication with him/her, both the child's physician and parent/guardian must indicate the need in writing.**

*** If a new medication is prescribed for your child by his/her physician, the initial dose should be administered prior to the first school dose.**

Please contact the school nurse at your child's building if you have any questions.

Health Services Department

Rev. 3/03

HEMPFIELD AREA SCHOOL DISTRICT

MEDICATION POLICY/PROCEDURE

All medications will be administered by or under the supervision of the school nurse, the school principal or the designee of the principal or the parent/guardian. According to discretionary policy, the principal may investigate incidents in which students are observed to be taking medication on their own without parent/guardian direction and school notification.

PRESCRIPTION AND NON-PRESCRIPTION MEDICATION

The procedure for prescription and non-prescription medication is the same.

- 1. A "PHYSICIAN'S SCHOOL MEDICATION DIRECTIVE" form must be completed by the student's physician to include:**
 - a. name, age of student**
 - b. diagnosis**
 - c. name of medication**
 - d. dosage prescribed**
 - e. time to be given**
 - f. physician's signature and the date**

PARENT/GUARDIAN RELEASE OF LIABILITY

(This section must be completed and signed by the Parent/Guardian.)

- 2. A "PERMISSION TO ADMINISTER AND MAINTAIN MEDICATION" form must be completed by the parent/guardian to include:**
 - a. student's name, grade, room**
 - b. name of medication, physician prescription and prescription number (if appropriate)**
 - c. dosage**
 - d. time**
 - e. frequency to be administered**
 - f. signature of parent/guardian, date signed, and a telephone number**
- 3. Parent/Guardian must supply medication in the original container. A prescription medication will be clearly labeled by the pharmacy or physician. Your pharmacist can supply a second labeled bottle for school use.**
- 4. Non-prescription medication must be supplied by the parent/guardian in a clearly labeled original container (directions must be visible).**
- 5. Written dated orders from the physician must accompany ANY CHANGE in the medication prescription.**

*** The School Nurse may contact the physician's office.**

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PHYSICIAN'S SCHOOL MEDICATION DIRECTIVE

Name of Student/Patient

Date of Birth: _____ Age _____

The above named person is a patient of mine and is currently under my medical care. Because of the diagnosis listed below, medication needs to be given during the regular school day according to the following protocol:

Diagnosis: _____

Medication prescribed: _____

Dosage prescribed: _____

Time to be given: _____

* If the medication is an emergency medication, such as an inhaler, Epipen, and/or Benadryl, do you want the student/patient to carry the medication? _____ Yes _____ No

* The School Nurse may contact the physician's office.

Date: _____ Physician's Signature: _____

Parent/Guardian RELEASE OF LIABILITY FORM

I, the parent and/or legal guardian of _____, enrolled
(Student's Name) (Grade)
at _____, realizing the importance of
(School's Name)

administering medication to my child as prescribed by the child's physician, do hereby agree to relieve designated school personnel of any liability from any potential ill effects as a result of their giving my child the medicine as prescribed by the child's physician. I have discussed this with my physician and/or legal counsel (lawyer) and realize the ramifications and thoroughly understand the meaning of this statement.

Parent or Guardian's Signature

Date

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Please complete the following information and enclose with each medication you send with your child to be taken during school hours. Do not omit any information.

Student's Name _____ **Grade** _____ **Room** _____

Name of Medication

Prescribed by Physician? Yes _____ **Name of Physician** _____

Prescription No. _____ Name of Pharmacy _____

Dosage _____ at _____ for _____ days
(time/s) (number).

If the medication is an emergency medication, such as an inhaler, Epipen, and/or Benadryl, do you want your child to carry the medication? _____ Yes _____ No

I will take full responsibility for the medication that is to be given during school hours.

Signature of Parent or Guardian _____

Date _____ Phone _____ (Home) _____ (Business) _____

Medication must be brought to school in an original container appropriately labeled with the Date, Student's Name, Name of Medication, Dosage, and the Time to be given.

A written note from the Physician must accompany all prescription and non-prescription medications to be taken at school. A note from the Physician must accompany any change in the medication prescription.

*** The School Nurse may contact the physician's office.**

[illegible]