SCHOOL HEALTH SERVICES
Central Dauphin School District

AUTHORIZATION FOR SCHOOL MEDICATION

_____ ___/___/___ _____

Student Name | Date of Birth | Grade/Classroom

School: _____

School Phone Number _____ School Fax Number: _____

Physician to complete:

_____ _____ _____

Medication to be administered | Dose | Route

☐ Daily ☐ As needed for _____

Time to be given (or interval between "as needed" doses): _____

Duration (days, weeks, school year): _____

Diagnosis: _____

Special Conditions to observe: _____

___/___/___ _____

Date | Signature of Physician

_____ _____

Physician Phone Number | Printed Physician Name

See reverse for Parent Permission Form and District Procedure

I, _____, parent or legal guardian of _____ hereby request and authorize the Central Dauphin School District and its nurses and/or designated employees to administer or assist the student in self administration of medication to _____.

I understand and acknowledge: (a) that an Individual Health Care Plan will be developed that I will be required to sign describing the protocol for the administration or self administration of medication to my child: (b) that school personnel other than the school nurse may be involved in the administration of medication to my child; (c) that school personnel as appropriate may be advised of the administration of medication to my child; and (d) that my child may be excluded from certain activities as appropriate in view of the medication he/she is being administered. If anyone other than me or my spouse delivers the medication to the school district, the medication will be delivered in a sealed envelope signed by me. This agreement shall be effective for the school year or until revoked by me in writing. I agree and understand that I am responsible for delivering required medication to the school district in a suitable labeled container and that no medication will be administered that is not properly delivered and labeled. I hereby authorize any treating health care provider to discuss my child's medication, need for medication and related information with representatives of the Central Dauphin School District.

List all medications to be administered

1. _____ 3. _____

2. _____ 4. _____

_____ _____

Signature of Parent or Guardian Date:

ADMINISTRATION POLICY FOR MEDICATIONS

Parents may request that the school district administer medication to their children at school **when it is necessary for the medication to be administered during the school day**. Requests for medication will be treated as any other confidential school information.

1. A written physician's order must accompany each medication to be dispensed. No medication is administered by school personnel without specific written instructions from a physician.

2. Parent/guardian must sign a Parental Authorization Form for the administration of medication. (*Reverse side) This form indemnifies all employees in connection with the dispensation of medication as ordered by the physician.

3. Pharmacy containers must be clearly labeled with the child's name, name of physician, date of the prescription, name and telephone number of pharmacy, name of medication, dosage, and frequency of administration.

*Have physician complete reverse side and return to nurse's office.