

MIDDLETOWN AREA SCHOOL DISTRICT
ADMINISTRATION POLICY OF 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.

A written physician's order must accompany each medication to be dispensed. No prescription medication or over the counter medication will be administered by school personnel without specific written instructions from a physician. A parent/guardian must sign a Parental Authorization Form for the administration of medication. This form indemnifies all employees in connection with the dispensation of medication as ordered by the physician.

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. Over the counter medication must be in original container. Prescription medication will be counted upon receipt in the nurse's office. Parents sending medication to school should indicate the number of pills in the container.

MEDICATION CARD
PARENTAL AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION

I, _____, parent or legal guardian of _____, hereby request and authorize the Middletown Area School District and its nurses and/or designated employees to administer or assist my child in his/her self-administration of medication. I understand and acknowledge: (a) that school personnel other than the school nurse may be involved in the administration of medication to my child; (b) that school personnel as appropriate may be advised of the administration of medication to my child; and (c) that my child may be excluded from certain activities as appropriate in view of the medication he/she is being administered. I agree that I am responsible for delivering the medication to school and if unable to bring the medication to school will send the medication in a sealed envelope (in original container) and sign the outside of the envelope. No medication will be administered unless the medication is in the properly labeled container. I hereby authorize any treating health care provider to discuss my child's medication, need for medication and related information with representatives of the Middletown Area School District.

Signature of Parent or Guardian

Date

Student's Name _____ Grade _____

Please have your physician complete this form for any medication needs.

Dear Physician:

Please indicate the following information for each medication.
The physician should complete section A.

SECTION A

| MEDICATION | DOSAGE | TIME AM/PM | LENGTH OF TIME | DIAGNOSIS/ CONDITION |
|------------|--------|---------------|-------------------|-------------------------|
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Does the medication require the student to have limitations such as not participating in a specific school activity such as lab, sports, shop, driver's training? Physician(s) please specify: _____

Does the medication have possible side effects or contraindications? Physician(s) please specify: _____

Signature of Parent/Guardian _____

Date _____ Phone number _____

Signature of Prescribing Physician _____

Date _____ Phone number _____