

# SOUTHEAST DELCO SCHOOL DISTRICT

## CONFIDENTIAL AUTHORIZATION FOR MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS

PARENTS/GUARDIANS: PLEASE COMPLETE AND RETURN TO THE SCHOOL NURSE

**I. The following section is to be completed by the PARENT/GUARDIAN:**

School _____		Grade _____
Child's Name _____	Last _____	First _____ Middle _____
Physician's Name _____	Address _____	Telephone Number _____

I request that my child be assisted in taking the medicines(s) described below at school by authorized persons or permitted to medicate herself/himself as also authorized by me and my physician (see below).

Parent/Guardian Signature _____	Date _____	Home Phone _____	Emergency Phone _____
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**II. The following is to be completed by the PHYSICIAN:**

**A. If medicine is to be given DAILY.**

Diagnosis for which medication is given: \_\_\_\_\_

Name of medicine \_\_\_\_\_

Dosage \_\_\_\_\_ Time \_\_\_\_\_

List significant side effects: \_\_\_\_\_

**B. If medicine to be given "WHEN NEEDED:**

Name of Medicine \_\_\_\_\_

Dosage \_\_\_\_\_ Time \_\_\_\_\_

Describe indications/diagnosis of usage \_\_\_\_\_

How soon can it be repeated? \_\_\_\_\_

List significant side effects: \_\_\_\_\_

**C. Other information: \_\_\_\_\_**

Name of Physician \_\_\_\_\_ Telephone # \_\_\_\_\_

Date \_\_\_\_\_ Physician's Signature \_\_\_\_\_

**NOTE: NO MEDICATION WILL BE ADMINISTERED IN SCHOOL EXCEPT BY DIRECT ORDER OF THE FAMILY PHYSICIAN.**

(PARENTS PLEASE READ INFORMATION ON BACK OF FORM)

## **SOUTHEAST DELCO SCHOOL DISTRICT**

### **PARENTAL REQUEST TO DISPENSE MEDICATION IN SCHOOL**

When medication is to be administered in school by school personnel, written permission must be obtained from the student's licensed physician. Parental or guardian request and authorization to give each specific medication must accompany the physician's written request/approval form. Medication must be in the original labeled pharmacy container with the student's name, medication identification, dosage and time interval written on the label -- with the physician's name and date of prescription, and the name and telephone number of the pharmacy.

All medications, prescription or non-prescription, are to be administered in the above procedure. Parents may come to school to administer medication to their children if they prefer to do so.

### **PROCEDURES:**

The following procedures should be implemented by district nurses:

1. Encourage parents or guardians to administer all short term medication before and/or after school hours.
2. If medication must be given in school, a physician's written request must be submitted to the nurse. Have the physician complete the district's Prescribed Medication Form. The written request for administration of a specific medication should include: date, student's name, diagnosis, medication, dosage, how administered, time schedule, and length of time to be administered in school; possible side effects or contraindications, any curtailment of school activity, other medication being prescribed by the physician, physician's signature, telephone number and address.
3. Parental or guardian written request and authorization to give each specific medication must accompany the physician's written request/approval. Parents' or guardians' request for the dispensing of medication during school hours without this written request of a physician shall not be acceptable.
4. Medication must be in the original labeled pharmacy container with the student's name, medication identification, dosage, time interval written on the label, and with the physician's name, date of prescription as well as the name and telephone number of the pharmacy.