# ANY MEDICATIONS SENT TO SCHOOL MUST HAVE THE REVERSE SIDE OF THIS FORM COMPLETED.

## UNIONTOWN AREA SCHOOL DISTRICT

## STUDENT MEDICATION PROCEDURE

Parents have the primary responsibility for the health of their children. There is no legal obligation for the District to assume responsibility for distributing medications to any child. However, in the interest of cooperation, the District is willing to work with parents when it is necessary for medications to be distributed during school hours, so long as the following guidelines are followed:

1. Parent and Physician must complete the **Authorization For Medication During School Hours** form on reverse side.

2. Send only those prescription medications which must be given during school hours. (Medications given three times per day should be given before and after school.)

3. **IMPORTANT:** All medication including over-the-counter medications **MUST** be sent in the most current pharmacist labeled container and will be stored in a locked cabinet in the nurses office.

4. Parents/Guardians must bring medication to the office. **Do not** send medication with your child on the school bus. Medication will be prohibited in desks, locker, or carried by students during the school day.

5. The child is to go to the nurse's office and request his/her medication at the scheduled time.

6. Over-the-counter medication **WILL NOT** be given at school without a doctor's authorization, ie: cough drops, creams, over-the-counter eye drops, etc.

7. If for any reason you cannot or will not comply with these guidelines, you have the option of coming to the school and distributing the medication yourself or sending some other person to do this for you.

**If you wish to discuss these procedures, please contact the nurse assigned to your child's building.**

**PLEASE COMPLETE REVERSE SIDE**

# AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS

## PHYSICIAN'S STATEMENT

To: _____ DATE: _____
(Full Name of Building Principal)

Please permit: _____ to take the following medication, according to the instructions of physician of record as indicated below, during school hours in order to maintain sufficient health to participate in the school program.

Name of Medication _____

Prescribed Dosage and Time Schedule: _____

Length of Time: _____ Days _____ Months _____ Indefinitely _____

Diagnosis _____

Possible Side Effects _____

**For Inhaler and Epi-Pen Medication Only**

****Physician must initial one of the following:**

_____ It has been determined that this student is able to self-administer and carry inhalant medication or EPI-Pen and has been trained in it's use including knowing when the medication is to be used.

_____ This student should not self-administer inhalant medication or Epi-Pen.

Physician: Please note any necessary emergency response to be taken should an adverse reaction to inhalant medication occur. _____

_____

Physician's Signature _____ Date _____/_____/_____

Physician's Name (Printed) _____

Address: _____ Phone: _____

## PARENT/GUARDIAN AUTHORIZATION

I understand that:

- no medication will be administered without proper authorization
- any change in medication, dosage, etc. requires new authorization
- all medications should be turned in to the office/school nurse by the parent

I, the undersigned parent/guardian of the above named student, hereby authorize the Uniontown Area School District to distribute the medication as indicated above to my son/daughter in accordance with the Physician's Statement. I do hereby release, discharge and hold harmless the Uniontown Area School District, its agents and employees from any and all liability and claims whatsoever relevant to or in connection with the administration of the above medication.

Signature of Parent/Guardian _____ Date _____/_____/_____

Phone number where parent/guardian may be reached _____

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