WEST JEFFERSON HILLS SCHOOL DISTRICT

PARENT/GUARDIAN: FILL IN TOP BLANK LINES. THE DOCTOR MUST COMPLETE THE BOTTOM.

Student_____**Birthdate**_____ **Gr/Hr**_____ /_____

In accordance with school policy, medication(s) should be given at home before and/or after school. When this is not possible, prior to receiving the medication at school, each student must provide the school nurse with a **Medication Administration Consent** form **signed** by the parent/guardian and a **Medication Order** from a licensed physician, dentist, CRNP or PA. **Prescription medication must be in the original prescription container from a pharmacy. Over the counter medications must be sent in the manufacturer's original container.**

Parental Directive for Administration of Medication

I understand that the West Jefferson Hills School District makes an effort to ensure that only licensed health care professionals administer the medications at schools. However, I also acknowledge and understand that there may not be a licensed health care worker in my child's school at all times during the school day. *For Inhaler, EpiPen, Insulin, or emergency medications only: I give permission for my child to carry and self-administer the emergency medication in school and on field trips as directed by the Licensed Prescriber on this form.* I acknowledge that the School District is not responsible for ensuring that my child's self-administered medication is taken. I hereby release, discharge and hold harmless the School District, its agents and employees, from liability for any act or omission committed in connection with administration of my child's prescribed medication. **Medications to be transported to school by parents/guardian.**

I, the parent/guardian of _____, have provided the school with the necessary
(Print Child's Name)
forms from my child's doctor to have the medication administered during the school day or on a school sponsored trip.

Parent/Guardian Signature_____ **Date**_____

Print Parent/Guardian Name_____ **Phone** _____

THE DOCTOR/HEALTHCARE PROVIDER MUST COMPLETE THE SECTION BELOW:

Medication_____**Dose**_____

Time & Frequency _____ **Route**_____

Give Daily? YES_____ **NO**_____ **P.R.N. Indications** _____

D\C Date (limit one school year) _____ **Allergies**_____

Precautions_____

Inhaler: The child was instructed and is able to demonstrate correct inhaler use. He /she is responsible to carry the inhaler for independent self-administration. **YES**_____ **NO**_____

EpiPen: The child was instructed and is able to demonstrate correct EpiPen use. He /she is responsible and will carry the EpiPen for independent self-administration. **YES**_____ **NO**_____

Give EpiPen immediately after ingestion of allergen food or bee sting? **YES**_____ **NO**_____

If NO: List ***symptoms*** for ***Antihistamine***_____

List ***symptoms*** for ***EpiPen***_____

Insulin: The child was instructed and is able to demonstrate correct Insulin use. He /she is responsible and will carry the Insulin for independent self-administration. **YES**_____ **NO**_____

Doctor/Prescriber Signature_____ **Date**_____

Doctor/Prescriber Name Printed_____ **Phone**_____

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