

COUNCIL ROCK SCHOOL DISTRICT
School Health Services

Dear Parent or Guardian:

MEDICATION/TREATMENT GUIDELINES

- The Medication/Treatment Dispensing Form on the reverse side must be completed by both the prescribing licensed provider (physician, dentist) and the parent/guardian for all medication (prescription and over the counter) that must be administered during the school day. No medication will be administered without the proper completion of the Medication/Treatment dispensing form.
- Medication will be administered to a student during school hours only when such medication is needed by the student to remain in school and administration is required during school hours. If possible, prescribing licensed providers should time administration of medication before or after school.
- Prescription medication as well as non-prescription medications must be delivered to the school nurse in the original labeled pharmacy container or box by a parent/guardian.
- Failure to provide documentation will require the parent/guardian to be present in school to administer the medication personally.
- Under no circumstances will the first dose of an antibiotic be given at school due to the risk of an adverse reaction.
- Acetaminophen, for which the district has a standing order from the district physician, will be administered as needed to all students with the signed permission of a parent or guardian as noted on the student's emergency information form.
- Ibuprofen, for which the district has a standing order from the district physician, will be administered as needed to students in grades 7-12 with the signed permission of the parent or guardian as noted on the student's emergency information form
- In accordance with Act 187 of the school code and CRSD procedures, students requiring rescue inhalers and Epi-pens may be permitted to carry and self-administer medications with a completed Self Administration of Medication form and a competency assessment by the school nurse.

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PERMISSION TO ADMINISTER MEDICATIONS IN SCHOOL

The following to be completed by the licensed prescriber

Patient's name _____ Date _____
Name of medication _____
Dosage _____ Time to be given _____ Route _____
Reason for Medication/Treatment _____
Directions _____
Effective date's _____ to _____
Allergies _____
It is my understanding that the employees of the Council Rock School District charged with the administration of this treatment/procedure during school hours may rely on directions contained in this document. I further certify that I am the physician/dentist who prescribed the treatment/procedure and that the student named above is under my supervision as a patient.
<input type="checkbox"/> It is my professional opinion that this child should carry his/her prescribed medications (CIRCLE ONE: Inhaler, EpiPen, Diabetic Medications) by him/herself
Licensed Prescriber signature _____
Licensed Prescriber printed name _____
Licensed Prescriber telephone number _____

Parent/Guardian Consent

I give my permission for my child, _____, to receive the following medication ordered by a licensed prescriber during the school day and release the Council Rock School District and its employees from liability for any damages my child may suffer because of this request. I understand that the medications will be given by school health personnel according to my child's licensed prescriber's directions.

Parent/Guardian signature _____ **Date** _____

Parent/Guardian name printed _____ **Phone:** _____