BETHEL PARK SCHOOL DISTRICT

BETHEL PARK, PENNSYLVANIA

# REQUEST FOR ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

The Bethel Park School District requests that medication be administered at home during non-school hours. We do, however, recognize that sometimes it is essential for medication to be administered at school. No prescription or "over-the-counter" medications will be given to any student without an order from a physician, along with signatures from the physician and the parents/guardian. All "over-the-counter" medication MUST be in the original manufacturer's container with the student's name written on the container. All prescription medications MUST be in a pharmacy labeled container. The pharmacy labeled container must include the name and phone number of the pharmacy, the name of the student, the physician's name, the name of the medication, the currently prescribed dose, time of administration and the Rx number.

Prescription medication in a pharmacy labeled container dated within the last 2 weeks and to be administered for NO MORE THAN 10 SCHOOL DAYS requires a parent's/guardian's signature & the completion of the information below. Medication prescribed for longer than 2 weeks also requires a physician's signature.

Student's Name: Last First Grade Age

Physician's Name (print) Phone Number

I understand fully the directions that have been given to the school by the physician and agree to permit the school to administer this medication to my child. In consideration of the school district's agreement to use good faith efforts to properly administer this medication, the district is hereby relieved from liability for any failure to properly administer this medication. I also authorize the school to contact the physician regarding said medication.

Date Parent/Guardian Signature Phone Number (home/cell/work)

## TO BE COMPLETED BY THE PHYSICIAN:

| |
|---|
| **Name of Medication:** |
| **Diagnosis (reason medication is prescribed):** |
| **Dose:** **Route:** |
| **If medicine is to be given "when needed" describe indications:** |
| **If medicine is to be given daily, at what time?** |
| **How soon can it be repeated?** |
| **List Significant side effects:** |
| **Length of time treatment is recommended:** |

Other Information_____

_____

Date Physician's Signature

# Medication Record: Administration

School Year_____ School_____

Student_____ DOB:___/___/___ Grade:_____

Medication/Dose_____ Route/Time_____

Physician/Physician's Address_____

| | August | September | October | November | December | January | February | March | April | May | June |
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The following people have given the medication:

Initials:_____ Signature_____ Initials:_____ Signature_____
Initials:_____ Signature_____ Initials:_____ Signature_____
Initials:_____ Signature_____ Initials:_____ Signature_____
Initials:_____ Signature_____ Initials:_____ Signature_____

**Codes**:

**H**: Holiday **A**: Absent **N**: None Available **F**: Field Trip **D**: Early Dismissal **W**: Dose Withheld **O**: No Show