Quakertown Community School District

Return this form to your child's building's Nurse

MEDICATION DURING SCHOOL HOURS CONSENT

Child's Full Name: _____ School: _____ Grade: _____

Whenever possible, parents/guardians should administer medications at home. However, we realize that at times your child may need to take medication during school hours. Medication(s) will be administered in school by licensed personnel only in accordance with a written medication order by a licensed prescriber, and the written consent of a parent/guardian. This includes prescription, over-the-counter, and complementary and alternative medicines.

You, the parent/guardian, **MUST** complete the following and return to your child's school nurse:

I request that employees of the Quakertown Community School District supervise my child's taking of the medication listed below. I release the school district and its employees from liability for any damages my child may suffer as a result of this request. I understand that this medication may not be shared with another student and that such an act is a violation of the school district's drug and alcohol policy. I give my permission for the School Nurse to speak with the physician regarding this medication prescription.

Parent/Guardian signature: _____ Date: _____

Parent/Guardian name printed: _____ Phone: _____

Prescription and non-prescription medications sent to school must always be in the ***original container and stored in the nurse's office***. Whenever possible, a parent/guardian should deliver the medication to the nurse's office. ***Students may carry asthma rescue inhalers, EpiPens, and diabetes supplies only with a physician's order and demonstrated competency to self-administer these medications.***

Your physician **MUST** complete the following:

Licensed Prescriber Medication Order:

Patient's name: _____ **Date:** _____
Name of medication: _____
Route and dosage: _____
Time of administration: _____
Directions: _____
_____
Discontinuation date: _____
Allergies: _____

( ) MD to initial: ***I certify that it is imperative that this child carries the above medication during the school day. This child has verbalized an understanding of when it is appropriate to administer this medication and has demonstrated the ability to self-administer this medication.***

Licensed prescriber signature: _____

Licensed prescriber name printed: _____ **Phone:** _____