SOUTH FAYETTE TOWNSHIP SCHOOL DISTRICT

Fax 724-693-2762 (K to 2) Fax 724-693-8084 (3 to 5)
Fax 724-693-0860 (6 to 8) Fax 724-693-9843 (9 to 12)

REQUEST FOR ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

The South Fayette Township School District requests that medication be given at home during non-school hours. However, it recognizes that sometimes it is essential for medication to be administered at school. *Any medication to be administered during school hours must include both physician and parent signature.* No "**over-the-counter**" medication will be given to any student without an order from a physician, along with signatures from the physician and parent. All **PRESCRIPTION** medication must be in a pharmacy labeled container. The label must include the name and phone number of the pharmacy, the pupil's name, the physician's name, the medication, the currently prescribed dose, time of administration and the Rx numbers. All **NONPRESCRIPTION** medication must be in an original container.

All medications shall be brought to the school by the parent and kept in the nurse's office. If this is not possible, the pharmacy-labeled container or original manufacturer's package must be sent to school in a sealed envelope with a note signed by the parent/guardian stating the number of tablets being sent to school.

Asthma inhalers may be carried and self-administered as long as self-administration is authorized by both parent and physician, and appropriate contract is signed by the student, parent, and school nurse.

STUDENT'S NAME
LAST:_____________________________FIRST:______________________GRADE:______AGE:______

PHYSICIAN'S NAME (please print):____
PHYSICANS'S PHONE_________________________________FAX______________________________

DIAGNOSIS:____

NAME OF MEDICINE:______________________________DOSAGE:____________ROUTE:_________

IF MEDICATION IS TO BE GIVEN **DAILY**, AT WHAT TIME?_________________________________

IF MEDICATION IS TO BE GIVEN **"WHEN NEEDED"**,
DESCRIBE INDICATIONS:____

HOW SOON CAN IT BE REPEATED?____

LIST SIGNIFICANT SIDE EFFECTS:____

LENGTH OF TIME THIS TREATMENT IS RECOMMENDED?__________________________________

IF INHALER CAN STUDENT CARRY AND SELF-ADMINISTER?______

PHYSICIAN'S SIGNATURE:_____________________________________DATE:__________________

TO BE COMPLETED BY PARENT/GUARDIAN:

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. I the case of an inhaler or epipen, I will see the nurse to review and sign the self-administration contract. 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 the same. I also authorize the school to contact said physician regarding this medication

PARENT/GUARDIAN SIGNATURE:_________________________________DATE:________________