CORRY AREA SCHOOL DISTRICT

540 E. PLEASANT ST.
CORRY, PA 16407
District Phone: 814-664-4677 fax# 814-664-3650

PARENT/GUARDIAN MEDICATION CONSENT FORM

Dear Parent or Guardian,

It is a policy of the Corry School District to administer prescribed medication during school hours **ONLY WHEN ABSOLUTELY NECESSARY**. You may come to school and give your child his/her medication if you wish. If your child is to receive prescribed medication during the school day, the **parent/guardian** is responsible to:

1. Complete this form
2. Have your child's doctor complete the Doctor's portion of Medication Form
3. Return all forms to your child's School Nurse
4. Bring the medication to your child's school in the container with the current prescription label. **DO NOT USE AN UNLABELED BOTTLE.** Ask your pharmacist for a second vial if necessary.
5. Notify the School Nurse if there is **ANY CHANGE** in the **TYPE** or **DOSE** of medication.
6. Pick up leftover medication at the end of the school year.

****** Remember parents/guardians are to assume responsibility to deliver the medication to the school nurse******

The Parent/Guardian Medication Consent and the Doctor's Medication forms **must be renewed each school year** that your child continues to need medication in school.

We share your concern for your child's health. Thank you for your cooperation in this important matter.

I give my permission for the school nurse or other person designated by the Corry District Board Policy to give the following prescribed medication(s) to my child during school hours.

As parent/guardian of _____grade_____, I hereby release the Corry Area School district and all its employees from any and all liability for damages my child may suffer as a result of this request, also understanding that the school entity bears no responsibility for ensuring that the medication is taken.

_____ _____
Parent/Guardian Signature **Date**

_____ **Medical or ACCESS card _____yes _____no**
Parent/Guardian Address and Phone number

Name of Medication (s) _____

Dosage _____ **Time to be given** _____

Reason for Medication(s)/Diagnosis_____

Name and address of Doctor who prescribed this medication (must match doctor's name on pharmacy bottle).

_____
Physician/PA/CRNP name **Address of practice** **Phone**

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PRIVATE PHYSICIAN REQUEST FOR ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS.

Dear Physician, PA, CRNP,

The parent/guardian of _____, a student at_____ requests that we administer medication to their child during the school day.
It is our opinion that medication should be given before or after school hours whenever possible. If it is essential that the student receive the medication(s) during school hours, please complete the following information. Please understand that occasionally medication time may have to be adjusted to accommodate class schedules.

Thank you for your cooperation

_____

School Nurse **School Building** **Phone/Fax**

This section to be completed by the Physician/PA/CRNP

Medication(s)_____

Diagnosis/Reason for medication(s)_____

Dosage:_____ **Time:**_____

If medication is to be given "prn", describe the indications and intervals_____

List significant side effects_____

Contraindications/Curtailment of specific school activity?_____

Please address the following in compliance with Pennsylvania Legislative Act no.101 Section 1414:

It is medically necessary for this student to carry his/her inhaler/epi-pen at all times. YES___ NO___
Student has been given instruction in how and when to administer his/her inhaler/epi-pen. YES___ NO___
This student demonstrates competency in use and frequency of use of inhaler/epi-pen. YES____ NO____
This student is qualified and able to self-administer his/her inhaler/epi-pen. YES____ NO____

Other medication(s) prescribed for this student being taken outside of school hours_____

_____

_____ _____

Physician/PA/CRNP signature **Date**

_____

Print full name **Address of Practice** **Phone**