PENNSBURY SCHOOL DISTRICT
134 Yardley Avenue • Post Office Box 338
Fallsington, Pennsylvania 19058-0338
Telephone: (215) 428-4100
FAX: (215) 295-8912
www.pennsburysd.org

PERMISSION TO ADMINISTER MEDICATION

Dear Parent/Guardian:

1. Medication will be administered to students **ONLY** when:
   a. failure to take the medication will jeopardize the health of the student, or
   b. the student would not be able to attend school if the medication is not administered during school hours

2. No medication will be administered without a written request from the parent/guardian using the tear off form on the reverse side.

3. Prescription medication **MUST** be sent in the original pharmaceutical container. Samples of prescription medication **MUST** be accompanied by a physician's order (note) to take the medication during school hours.

4. Over-the-counter medications will **NOT** be administered unless they are in their original container and accompanied by a physician's order to take the medication during school hours.

5. If you would like your son/daughter at the 6th-12th grade levels to self-administer a medication during the school day (e.g. inhaler, epipen), written permission from the child's physican is necessary. Elementary grade levels also require a doctor's order for self-administration which will be at the discretion of the school nurse after the child has demonstrated the ability to use the inhaler properly.

6. All drugs that are controlled by the Federal Narcotics Act **MUST** be brought to school by the parent/guardian and not sent to school with the student, or they will not be administered. This policy includes medications for overnight field trips.

Thank you for your cooperation and adherence to the above procedures.

Please see the reverse side...

Please cut along this line

I hereby request that school personnel administer the medication indicated below to my son/daughter

Student's Name: _____ Grade: _____

OR

I hereby request that my son/daughter

Student's Name: _____ Grade: _____

be permitted to self-administer the medication indicated below during school hours.

I hereby release school employees from any liability or responsiblity for any injury or damages that may result from the administration of medication in accordance with this request, under the conditions indicated below:

Name of Medication: _____

Name of Prescribing Physician: _____

Purpose of Medication: _____

Dosage: _____

Special Instructions: _____

Possible Side Effects: _____

Date: _____ Signature of Parent/Guardian: _____