COUNCIL ROCK SCHOOL DISTRICT

School Health Services

Dear Parent or Guardian:

MEDICATION/TREATMENT GUIDELINES

- The Medication/Treatment Dispensing Form on the reverse side must be completed by both the prescribing licensed provider (physician, dentist) and the parent/guardian for all medication (prescription and over the counter) that must be administered during the school day. No medication will be administered without the proper completion of the Medication/Treatment dispensing form.
- Medication will be administered to a student during school hours only when such medication is needed by the student to remain in school and administration is required during school hours. If possible, prescribing licensed providers should time administration of medication before or after school.
- Prescription medication as well as non-prescription medications must be delivered to the school nurse in the original labeled pharmacy container or box by a parent/guardian.
- Failure to provide documentation will require the parent/guardian to be present in school to administer the medication personally.
- Under no circumstances will the first dose of an antibiotic be given at school due to the risk of an adverse reaction.
- Acetaminophen, for which the district has a standing order from the district physician, will be administered as needed to all students with the signed permission of a parent or guardian as noted on the student's emergency information form.
- Ibuprofen, for which the district has a standing order from the district physician, will be administered as needed to students in grades 7-12 with the signed permission of the parent or guardian as noted on the student's emergency information form
- In accordance with Act 187 of the school code and CRSD procedures, students requiring rescue inhalers and Epi-pens may be permitted to carry and self- administer medications with a completed Self Administration of Medication form and a competency assessment by the school nurse.

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PERMISSION TO ADMINISTER MEDICATIONS IN SCHOOL

The following to be completed by the licensed prescriber

Patient's name ____ Date ___________________

Name of medication ____

Dosage ________________ Time to be given ________________ Route ________________

Reason for Medication/Treatment____

Directions ____

Effective date's _________________to________________

Allergies ____

It is my understanding that the employees of the Council Rock School District charged with the administration of this treatment/procedure during school hours may rely on directions contained in this document. I further certify that I am the physician/dentist who prescribed the treatment/procedure and that the student named above is under my supervision as a patient.

☐ **It is my professional opinion that this child should carry his/her prescribed medications (CIRCLE ONE: Inhaler, EpiPen, Diabetic Medications) by him/herself**

Licensed Prescriber signature ____

Licensed Prescriber printed name____

Licensed Prescriber telephone number____

Parent/Guardian Consent

I give my permission for my child, ____, to receive the following medication ordered by a licensed prescriber during the school day and release the Council Rock School District and its employees from liability for any damages my child may suffer because of this request. I understand that the medications will be given by school health personnel according to my child's licensed prescriber's directions.

Parent/Guardian signature __________________________________ **Date** ________________

Parent/Guardian name printed ___________________________ **Phone:** _________________