Policy No. 210 AR -1

WEST ALLEGHENY SCHOOL DISTRICT
Medication Form

Authorization for Prescription or Non-Prescription Medications to be Taken During School Hours

The West Allegheny 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.

- Prescription medication must be in a container labeled by the Pharmacy.
- Over-the-counter medication must be in the original container.

Additionally, a written order from the physician as well as written consent from the parent for administration of the medication is required.

Parent to Complete this Section**

_____ _____ _____

Student's Last Name, First Name | Date of Birth | Grade

_____ _____

Physician's Name (print) | Physician's Phone

Student Allergies:_____

Current Medications:_____

I fully understand the directions that have been given to the school by the physician and I give my consent for the medication prescribed below to be administered to my child at school or for the school to monitor the self-administration of the medication (Epi-Pens, inhalers, and Insulin) to my child.

I also authorize necessary school personnel to contact the medical provider named above regarding this medication if there would be any questions that should arise.

_____ _____ _____

Date | Parent/Guardian Signature | Home Phone / Cell Phone

Physician to Complete this Section**			
To be given during school:	**Medication #1**	**Medication #2**	**Medication #3**
Name of Medication:			
Dose/Route:			
Indication/Reason to be given:			
Time/Frequency to be given:			
Date to be initiated:			
Date to be discontinued:			
Special Instructions: (describe indications)			
Possible adverse reactions:			
Emergency response:			

Insulin only:

This student is capable of self-administration: Yes ___ No ___

Comments:

_____

Inhalers & Epinephrine auto-injectors only:

This student is capable of self-administration: Yes ___ No ___

This student may carry their inhaler or epinephrine auto-injector on their person Yes ___ No ___

Comments:_____

COMPLETE THIS SECTION ONLY IF STUDENT SELF-ADMINISTERS INSULIN, ASTHMA INHALER, OR EPINEPHRINE AUTO-INJECTORS:

☐ INSULIN – Student acknowledges that they have received instruction from their health care provider on proper safety precautions for the handling and disposal of the medications and monitoring equipment. They will not allow other students to have access to the medication and monitoring equipment.

☐ INHALER/EPINEPHRINE AUTO-INJECTOR - Student acknowledges that they have received instruction from their health care provider on proper safety precautions for the handling and disposal of asthma inhaler and/or epinephrine auto-injector. They will notify the school nurse immediately following the use of an asthma inhaler or epinephrine auto-injector. They will not allow other students to have access to the prescribed medication and understands the safeguards.

STUDENT SIGNATURE: _____ Date: _____

The school nurse acknowledges that the student is competent and able to self administer medication, asthma inhaler, or epinephrine auto-injector and use the monitoring equipment.

NURSE SIGNATURE: _____ Date: _____

PHYSICIAN SIGNATURE: _____ Date: _____

PRINT PHYSICIAN NAME: _____ Date: _____

Anytime there are medication changes, this form must be updated the parent/physician.
Revised 4/4/2024