



**SPRING GROVE AREA SCHOOL DISTRICT
SPRING GROVE, PENNSYLVANIA**

**PRIVATE PHYSICIAN AND PARENT REQUEST
FOR ADMINISTRATION OF MEDICATION DURING SCHOOL DAY**

To be completed by licensed prescriber:

It is the practice of the Spring Grove Area School District to request that medication be given to student before or after school hours whenever possible. If it is essential that a student receive the medication(s) during school hours, please complete the following information:

Name of Student:		Date of Birth:
Grade/Homeroom:		
Medication	#1	#2
Dosage		
Time of Administration		
Length of Administration		
Reason for Administration		
Administration Instructions		
Side Effects/Activity Curtailment		
Competency for Self Administration	I, _____, certify that this student has a potentially life threatening illness and requires an inhaler or auto injecting epinephrine. This student is competent and has been instructed in the proper method of self administration of said medication. This student may therefore carry and self administer his/her inhaler or auto injecting epinephrine.	

**** Medications are permitted on a field trip when 1) failure to take the medication would jeopardize the health of the student and/or 2) the student would be unable to participate without the medication. School nurses are not always in attendance on field trips. Medication will not automatically be available in these circumstances. Please indicate below how this medication should be managed in the event of a field trip during the school day:**

- Yes, the prescribed dose can be withheld on the day of the field trip.*
- Yes, the time can be adjusted with the parent/guardian to be administered upon return to school.*

Physician's Signature: _____ **Physician's Phone No.** _____ **Date:** _____

TO THE PARENT/GUARDIAN:

I consent to communication with the health care provider(s) for treatment-related purposes. I give my permission for the school district personnel to administer the above prescribed medication to my child during school hours. *(Parents of students in grades K – 4 MUST deliver the medication in person.)* All medication must be in the original container, with the label indicating the **student's name, name of medication, name of physician and dosage (amount/frequency)**. Medication left at school will be discarded after a reasonable amount of time. Where self administration is deemed appropriate above by the physician, I agree to allow my child to carry his/her asthma inhaler or auto injecting epinephrine. Students are to report to the nurse in each instance that this medication is used.

In the event of a delayed opening of the school day:

Administer my child's medication as prescribed _____

No, I will contact you if the time is to be adjusted. _____

Parent/Guardian Signature: _____

Date: _____