Annville-Cleona School District
Health Services

## Consent Form for Administration of Medication at School

Student's Name_____Grade____Teacher_____DOB_____

**1. Medication**_____Diagnosis_____Dosage_____Time(s)_____

**2. Medication**_____Diagnosis_____Dosage_____Time(s)_____

**3. Medication**_____Diagnosis_____Dosage_____Time(s)_____

List any other medication(s) taken at home, including dosage and time schedule:_____

Other comments, special considerations/restrictions_____

## Parent/Guardian Consent for Medication Administration at School

I, parent/guardian of _____, give permission for my child to receive the above medication(s) during school hours. I also give the school nurse permission to contact the physician listed below to keep him/her informed of any side effects or concerns regarding medication administration. In the event of an emergency, the school may transport my child to nearest designated hospital.

**Parent/Guardian Signature**_____**Date**_____

## Annville-Cleona School District's Medication Policy

1. Medication must be transported to and from the school nurse office by an adult in its **original container with a label** that includes: child's name, instructions for administration, content identification and physician's name-unless authorized to self carry/administer epi pen/inhaler. (Refer to reverse side of form)

2. Medication order forms must be updated annually by parent/guardian and physician and medication is to be claimed within one week beyond the end of the school year.

## Medication Order by Authorized Healthcare Provider

**Physician's Signature**_____ Date_____

**Physician's Name** (print)_____ Phone# _____FAX#_____

***Medical order may be faxed to the student's assigned building nurse to be attached to the medical form.**

Fax Numbers:

| | | |
|---|---|---|
| Annville-Cleona Middle/Secondary School | Gwen Landis, CSN | 717-867-7712 |
| Annville Elementary School | Andrea Speraw, CSN | 717- 867-7624 |
| Cleona Elementary School | Janice Raynes, LPN | 717-867-7644 |

## EMERGENCY MEDICATIONS (EPIPEN AND INHALERS only):

___ It is my professional opinion that _____is both capable and responsible of carrying and self-administering during school hours/field trips/related school activities. The school nurse should be consulted if the student is having a health related complaint or uses his/her medication(s):

**___ Auto injectable epinephrine (0.15mg or 0.3mg) ___Inhaled asthma medication**

___ It is my professional opinion _____ should not carry his/her medication at school or school related activities. The medication should be kept with the nurse and supervised with administration.

Physician's Signature _____ Date: _____

Physician's Name (Print) _____ Phone _____ FAX _____

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## PARENT/GUARDIAN CONSENT
## FOR SELF-ADMINISTRATION OF MEDICATION

I hereby consent for my child,_____to self-administer the following medication(s) during the regular school day or when attending school related activities:

☐ **Auto-injectable epinephrine** ☐ **Inhaled asthma medication**

*I also consent to disclose identifiable health information by the health care provider to the school nurse or other personnel designated by Annville Cleona School District.

*I acknowledge that I have an obligation to notify the school if my child's medication, dosage, frequency of administration or reason for administration changes during school year.

*I understand and hereby acknowledge that neither the School District nor any employee of the School District shall be liable or responsible for the benefits or consequences of the prescribed medication or for ensuring that the medication is taken. As such, I hereby release the School District and its employees from any and all liability of any nature whatsoever related to the self-administration of the medicine.

_____ _____
Date Signature of Parent/ Guardian

_____ _____
Date Reviewed by School Nurse