PERKIOMEN VALLEY SCHOOL DISTRICT
MEDICATION PROCEDURE

ASTHMA INHALER PERMISSION TO CARRY/SELF-ADMINISTRATION BY STUDENT
(Signed permit good for current school year)

The authorization for Medication Administration must be completed and kept on file in the Nurse's office. It is not recommended that students carry or self-administer at the elementary school level. If the child may self-administer, additional medication should be kept in the nurse's office (in case the student forgets or misplaces his emergency medication). Students who self-administer medication such as an inhaler should notify the nurse as soon as possible after using the medication. The nurses will assess the health of the student, document the use of the medication, and arrange for further medical attention if needed. The student's name must be on the inhaler.

_____ _____ _____
Student's Name Grade Date

To self-medicate, the student must be able to: (check all that apply)
____ 1. Respond to and visually recognize his/her name.
____ 2. Identify his/her medication and correctly identify use as prescribed on pharmacy label.
____ 3. Demonstrate the proper techniques for self-administering his/her medication.
____ 4. Sign his/her medication sheet to acknowledge having taken the medication.
____ 5. Demonstrate a cooperative attitude in all aspects of self-administration of medication.

_____ _____ _____
Name of Medication Dosage Frequency

The above named student has demonstrated the ability to self-administer the physician-prescribed asthma medication, as indicated by the criteria listed above.

_____ _____
Date Signature (Certified School Nurse)

As the parent/guardian of above named student, I relieve the school district and its employees of any responsibility for the benefits or consequences of the above listed medication when it is physician-prescribed and parent/guardian authorized. I further acknowledge that the school bears no responsibility for ensuring that all medication is taken. I am aware that any improper use/sharing of the above named medication will result in the immediate confiscation of the inhaler and loss of privilege to self-administer if the medication policy is violated.

_____ _____
Date Parent/Guardian Signature

I agree to be solely responsible for my asthma inhaler and to follow the directions for its use as ordered by my physician, as well as the district's medication policy. I am aware that any abuse of this privilege will result in confiscation of my inhaler.

_____ _____
Date Student's Signature

This student has received instruction in my office regarding the safe handling and self-administration of the above medication.

_____ _____
Date Physician's Signature

(New 7/06) **(OVER)**

PERKIOMEN VALLEY SCHOOL DISTRICT
PROCEDURE FOR ADMINISTRATION OF MEDICATION

Dear Parent/Guardian:

According to the State Health Code, including the State Board of Nurse Examiners, the school nurse **may not administer** any medication **without a written order** from your child's physician indicating the name of the medication, the dosage, the reason it is being given, and the time to administer it in school. **This includes over-the-counter, non-prescription medication as well as prescription medication**. **Your signature is also required.**

In order for the school nurse to administer medications, the Perkiomen Valley School District requests that you ask your physician to complete the enclosed form. In the event your child needs medications, fill in the name of the medications on the enclosed form and ask your physician to sign it. Please have your child return the form to the school nurse. **Medication must be brought to school by the parent/guardian in its original container,** clearly labeled with child's name, name of medication, amount of dosage and time to be given.

After you and your physician complete the **Permit to Administer Medication** form, the school nurse will be glad to administer medication following the Pennsylvania State regulations. **Phone permission is not acceptable.** Thank you for your cooperation in this important matter.

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PERMIT TO ADMINISTER MEDICATIONS
(Signed permit good for current school year)

Student Name:_____Room/Section:_____

Name of Medication:_____

Amount to be Given:_____ Dates to be Given:_____

Time to be Given:_____ Reason for Medication:_____

Potential serious reaction or side effects of medication:_____

Any necessary emergency response:

_____ _____ _____
Signature of Physician Phone Number Date

_____ _____ _____
Signature of Parent/Guardian Phone Number Date

(New 7/06)