Pennridge School District
School Health Services

MEDICATION DISPENSING FORM

Medication will be administered to students during school hours only when such medication is needed by the student to remain in school and administration is required during school hours. **No medication will be administered to any student without proper completion of the Medication Dispensing Form.** This form needs to be used for both prescription and non-prescription drugs (over the counter products).

All medication to be administered by school personnel must be delivered in **the original and properly labeled container** to the school nurse, principal, or the principal's designee along with the Medication Dispensing Form. Prescription and non-prescription medicine will be locked in the nurse's office. **All medications must be delivered to the school health office by an adult. Students are not permitted to carry any medication with them in school. Exception – Properly labeled inhalers or Epi-Pens.** These medications need to be in the original prescription box. In the absence of a school nurse, the principal or principal's designee will administer the medication.

TO BE COMPLETED BY PHYSICIAN / DENTIST

Student's Name: _____ Age: _____ Grade: _____ School: _____

Name of Medication: _____ Specific Dosage: _____ Frequency: _____

Special Considerations: _____

Reason for Medication: _____

Effective Dates: _____ From: _____ To: _____

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

Signature of Physician/Dentist: _____

Printed Name of Physician/Dentist: _____

Address: _____

Telephone: _____ Fax: _____ Date: _____

TO BE COMPLETED BY PARENT / GUARDIAN
As parent/guardian of the above named student, I hereby request that the treatment described above be administered to my child and release the Pennridge School District and its employees from liability for any damages my child may suffer as a result of this request.

Signature of Parent or Guardian: _____

Home Telephone: _____ Work Telephone: _____ Cell Number: _____

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