Pennsylvania
School for the Deaf
100 West School House Lane | Philadelphia, PA 19144-3404
1-215-951-4700 V | 1-215-951-4708 F | www.psd.org

MEDICATION POLICY- MEDICATION PERMISSION FORM

Medication(s) should be given at home before and/or after school. However, when this is not possible, prior to medication being administered to a student during the school day, the parent/guardian or responsible adult must personally deliver to the school nurse the following:

1. Written orders from a qualified health care provider giving the child's diagnosis and the dosage and frequency of its administration for each prescribed medication.

2. Written permission from the parent/guardian for the school to comply with the qualified health care provider's order.

3. An explanation of the reason the medication(s) must be taken during school hours.

4. Medication in its original container properly labeled by the pharmacy or qualified healthcare provider or the over-the-counter medication in its original container as purchased. *One month supply only*. *School Nurse may only administer medication prescribed by a qualified healthcare provider.*

HEALTH CARE PROVIDER'S AUTHORIZATION

Student's name: _____ DOB:_____ Grade:_____

Diagnosis:_____

Medication 1: _____ Dosage _____ Frequency(TIME)_____

Possible side effects: _____

Restrictions: _____

Medication 2: _____ Dosage_____ Frequency(TIME)_____

Possible side effects: _____

Restrictions: _____

ASTHMA INHALER , EPINEPHRINE AUTO INJECTOR, INSULIN, and GLUCAGON:

Student is authorized to carry and self-administer? Yes___ No___

Reason medication(s) must be given by school personnel or self-administration during school hours:

_____

Field Trip: ***For daily medications only.*** The medication may need to be omitted or time changed during a field trip.
Please Indicate below.
Omit medication during the field trip: _____Time of medication may be changed to:_____

HealthCare Provider: _____ **Date** :_____
Signature (required)
Telephone No: _____

I (print parent/guardian name) _____ hereby give my consent for my child/student identified above to receive the above medication as prescribed and I release the Pennsylvania School for the Deaf of all responsibility for any benefit and any and all adverse consequences of the medication. I also give consent for Pennsylvania School for the Deaf Health Services Staff to communicate with the above Health Care Provider for the benefit of my child/student. *I understand that a new order is needed each school year and that any medications not picked up at the end of the school year will be discarded.*

Date: _____ **Parent/GuardianSignature:** _____