Parent

COATESVILLE AREA SCHOOL DISTRICT
PARENT CONSENT FORM FOR ANY PRESCRIPTION AND/OR OVER-THE-COUNTER MEDICATIONS

ALL medication - either over the counter or prescription - MUST be accompanied by a doctor's note.

Date_____

To The School Nurse:

As the parent/guardian of_____, I request that licensed school personnel (CNS, RN, LPN) administer the medication listed below to my child according to the directions from the physician. I hereby release the Coatesville Area School District School Board and its employees of liability for administration of medication.

I understand ANY medication sent to school MUST be in its original container. If it is not, the medication will not be dispensed.

Name of medication:_____

Dosage to be administered:_____

Time medication is to be given:_____

Date(s) medication is to be given:_____

Condition being treated:_____

Signature of parent/guardian:_____

"Guidelines for Pennsylvania Schools for the Administration of Medications and Emergency Care" from the PA Department of Health require a "medication order" from a licensed provider to administer prescription, over the counter, and herbal medicines.

ANY MEDICINE OF ANY KIND THAT IS BEING SENT TO SCHOOL FOR ANY REASON REQUIRES A DOCTOR'S ORDER.

Doctor's orders may be faxed to: 610-384-5730

Additional forms can be accessed on the C.A.S.D. web site

Physician

COATESVILLE AREA SCHOOL DISTRICT

MEDICATION ORDER FORM FOR ANY PRESCRIPTION AND/OR OVER-THE-COUNTER MEDICATIONS TO BE COMPLETED BY A LICENSED PROVIDER

Dear Physician,

According to "Guidelines for Pennsylvania Schools for the Administration of Medications and Emergency Care" by the Department of Health, school nurses need a "medical order" from a licensed provider to administer any prescription, over-the-counter, or herbal medicines. In the past we have required only parental consent. In order to simplify the procedure we've developed the form below which will be available to parents through the school nurse, in the student handbooks, and on the school district web site

We look forward to working with you to provide the best care we can for our students. If you have any questions, concerns or suggestions, please do not hesitate to contact me at_____

School Nurse

Date:_____

Name of Student:_____DOB_____

Name of medication:_____

Dosage to be administered:_____

Time medication is to be given:_____

Date(s) medication is to be given:_____

Condition being treated: _____

Signature of licensed medical provider:_____

Name of provider: _____

Phone number: _____

ANY MEDICINE OF ANY KIND SENT TO SCHOOL FOR ANY REASON REQUIRES A DOCTOR'S ORDER

THIS FORM MAY BE FAXED TO THE SCHOOL NURSE AT: 610 384-5730