In anticipation for the next school year, I am sending this form home now. Please have your child’s physician complete the medication form. Return it at the end of August or on the first day of school in September**. IF YOUR CHILD WILL BE CARRYING HIS/HER INHALER, PLEASE HAVE THE “CARRY OR SELF ADMINISTER MEDICATION” FORM COMPLETED (#21B).**

**NORTH PENN SCHOOL DISTRICT**

**LANSDALE, PA 19446**

Medication Policy

Prescription Medication:

 1. Sent to school in original container from pharmacist. \*

 2. Accompanied by two notes: one signed by the parent giving school personnel permission to administer, and

 the other signed by the physician which has complete instructions for administering.

Over the Counter Medication:

 1. Sent to school in original container labeled with student’s name

 2. Accompanied by a a note signed by parent/physician which has complete instructions for

 administering.

Medication must be brought directly to the Nurse’s Office by the student or parent **BEFORE** going to the classroom.

MEDICATION MAY NOT BE CARRIED BY STUDENTS IN THE SCHOOL BUILDING.

\* 2 bottles should be requested from pharmacy – one for home and one for school.

**REQUEST FOR SCHOOL TO ADMINISTER MEDICATION**

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grade/Homeroom \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Homeroom Teacher \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Medication\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Procedure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Medication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Duration of Treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have questions, please contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Parent Signature Physician Signature

\* ALL medications **MUST BE** brought to school in original container.

**WE MUST HAVE A PHYSICIAN’S SIGNATURE FOR EPI PENS, INHALERS AND ALL**

**LONG TERM (MORE THAN 3 WEEKS) MEDICINES.**