STO•ROX
SCHOOL DISTRICT

Medication Administration During the School Day

While it is preferred that medication is administered outside of school hours, we recognize the need at times for administration to occur during the school day. If your health care provider deems it medically necessary for your child to take medication during the day, the following procedures must be completed:

1. Written authorization from the licensed prescriber must accompany all medications. That written authorization may come in the form of:
- A completed STO-ROX Medication Permission form or
- Written note on the licensed prescriber’s letterhead or prescription notepad.
2. A parent/guardian must complete the Request for Administration of Medication in School Form for medication to be taken in school.
3. The initial dose of medication must be provided prior to request of administration at school.
4. All medication is to be in its original labeled container.
5. When someone other than the parent/guardian delivers medication to school:
- Container is to be placed in a sealed envelope.
- Medication is to be delivered to the health office upon student’s arrival at school.
- The parent assumes all responsibility for medications sent to school.
6. Acceptable amounts of medication to be stored at school:
- One-week supply for acute (short-term) illness
- Thirty-day supply for chronic (long-term) conditions
7. Changes in medication must be accompanied by a licensed prescriber’s written statement. A faxed written statement with licensed prescriber’s signature will be accepted.
8. In addition, for students who carry and self-administer emergency medications, an order is required from a licensed prescriber indicating that it is necessary for the student to carry the medication and that the student is competent of self administration.
9. See medication consent forms for ASTHMA – PRESCRIPTION – OVER THE COUNTER MEDICATIONS.

298 Ewing Road • McKees Rocks, PA 15136
Phone: 412.771.3213 • Fax: 412.771.0238

STO•ROX
SCHOOL DISTRICT

PRESCRIPTION MEDICATION CONSENT FORM

Student Name___________________________________Date of Birth ________________________

Grade_______________ Date __________________ School Year ____________________________

Medication/Treatment Plan Completed By PHYSICIAN / C.R.N.P / P.A.

Medication, dosage ____

Time for administration during school hours____

DAILY_______________ or PRN____

Specific instructions for administration:

_________________________ / _________________________________ /________________________

Date / Signature / Name (PRINT) – Physician / C.R.N.P. / P.A.

________________________ / _________________________________

Phone Number / Fax Number

ALL MEDICATION MUST BE SUPPLIED IN THE ORIGINAL PRESCRIPTION CONTAINER OR IT WILL NOT BE GIVEN.

Parent/Guardian Consent: I grant permission for the school personnel to assist in the administration of medication/treatment noted above, including when the student is away from school property on school business. I release Sto-Rox School District employees from all liability for damage my child may incur because of this request.

_________________________/____

DATE / SIGNATURE OF PARENT/GUARDIAN

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ASTHMA / INHALER MEDICATION CONSENT FORM

Student Name___________________________________Date of Birth _______________________

Grade______________ Date _________________ School Year ___________________________

Medication/Treatment Plan Completed By PHYSICIAN / C.R.N.P / P.A.

Medication, dosage ____

Time for administration during school hours____

DAILY______________ or PRN____

Specific instructions for administration:

____

________________________ / _______________________________ /_______________________
Date / Signature / Name (PRINT) – Physician / C.R.N.P. / P.A.

_______________________ / _______________________________
Phone Number / Fax Number

ALL MEDICATION MUST BE SUPPLIED IN THE ORIGINAL PRESCRIPTION CONTAINER OR IT WILL NOT BE GIVEN.

Parent / Guardian Consent: I request that school personnel comply with above order of the physician, including when the student is away from school property on school business. I acknowledge school personnel bear no responsibility for benefits or consequences of the above drug for the student, or responsibility that the medication is taken. I release Sto-Rox School District employees from all liability for damage my child may incur because of this request.

________________________/____
DATE / SIGNATURE OF PARENT/GUARDIAN

STO•ROX
SCHOOL DISTRICT

OVER-THE-COUNTER MEDICATION CONSENT FORM

Student Name_________________________________ Date of Birth______________________

Grade________ Date ____________________ School Year_____________________________

We, the parent/s, guardians of the above named student request school personnel to administer the following named medication(s).

NAME OF DRUG: ____

DOSE: ____

Time for administration during school hours__________________________

ALL MEDICATION MUST BE SUPPLIED IN THE ORIGINAL PRESCRIPTION CONTAINER OR IT WILL NOT BE GIVEN.

Medication will be given according to manufacturer's guidelines. NO other over-the-counter medication will be dispensed without parent/guardian consent form completed for specific medication.

Parent/Guardian Consent: I grant permission for school personnel to assist in the administration of medication/treatment noted above. I release Sto-Rox School District personnel from all liability for damage my child may incur as a result of this request.

_______________________/____
DATE / NAME (PRINT) OF PARENT/GUARDIAN

_______________________/____
DATE / SIGNATURE OF PARENT/GUARDIAN

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