STATE COLLEGE AREA SCHOOL DISTRICT
LEARNING ENRICHMENT AND STUDENT SERVICES HEALTH SERVICES
PARENTAL REQUEST AND PHYSICIAN'S ORDER
FOR STUDENT SELF MEDICATION DURING SCHOOL HOURS

If possible, medication should be taken at home. The administration of prescribed medication and over the counter medication to a student during school hours will be permitted only when **failure to take such medication would jeopardize the health of the student and/or the student would not be able to attend school if the medicine were not made available during school hours.**

This form is to be completed to implement self medication for students in grades K – 12 who need an inhaler or diabetic supplies, and for students in grades 9–12 for any prescription or other medication.

To self medicate, a student must demonstrate that they are capable and will be responsible. If medicine is prescribed by a physician only one day's supply may be brought to school each day and it must be carried in the original prescription labeled container. Over the counter medicine must also be carried in it's original container.

If a student shares for free or for payment any of his/her medication it will be dealt with as a violation of the State College Area School District Drug and Alcohol Policy. The student will receive appropriate consequences and no longer be permitted to self medicate.

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TO BE COMPLETED BY PARENT/GUARDIAN:

Student's Name___________________________________ Birth date___________ School___________ Grade ____________

I hereby authorize the State College Area School District to permit my child (name above) to self medicate, as indicated in the physician's order below or as indicated in my authorization below. (Parent/guardian may not authorize any medication which is a controlled substance, which is an illegal substance or which requires a physician's order, without the Physician completing the section below.

My child is permitted to take ____________________________________ at her/his discretion at school.
Name of Medication

I hereby release State College Area School District and all of its employees of and from any and all liability in law for damages either I or my child may suffer as a result of this authorization. I give my permission for the school nurse to exchange information with my child's physician regarding this medication.

______________________________ ____________________ ____________________ ____________________
Parent/Guardian Signature | Home Phone | Work Phone | Date

This portion must be completed for prescription medication.

TO BE COMPLETED BY PHYSICIAN:

Notice: The school district urges physicians to schedule medication, whenever possible, so that it can be taken at home under the supervision of the parents/guardians. School district staff will supervise pupils taking medication or the school district will only permit self medication during school hours if failure to take such medication would jeopardize the health of the student or if the student would not be able to attend school without taking the medication. **Physicians are reminded "self medication" means the student will take medication at his/her own discretion without intervention of the school nurse or staff.**

IT IS NECESSARY THAT (Student's name)_______________________________________RECEIVE THE FOLLOWING MEDICATION AT THE TIMES STATED BELOW.

____________________________________ ____________________________ __________________________________
Name of Medication | Dosage | Times to be taken

Route of Adminstration____

Student may self administer: [ ] Yes [ ] No Other Specific Directions____

Purpose of Medication and/or Diagnosis ____

Side Effects to Watch For____

Duration of Order____

_____________________ ______________________________ ____________________ _________________
Physician (Please Print) | Physician's Signature | Telephone Number | Date