# STAFFORD TOWNSHIP SCHOOL DISTRICT
# PERMISSION TO ADMINISTER MEDICATION AT SCHOOL

## SECTION 1 – TO BE COMPLETED BY A DOCTOR/HEALTHCARE PROVIDER

STUDENT NAME: ________________________________________________ GRADE: ____________________

DIAGNOSIS (purpose for administration of medication): ________________________________________

_____________________________________________________________________________________

MED ORDERS: The appropriate individuals as listed in Section 2 shall administer medication as follows:

Name of Medication: ____________________________________________________________________

Timing/Dosage: ________________________________________________________________________

Possible side effects: ___________________________________________________________________

Duration/End date: _____________________________________________________________________

ADDITIONAL MED ORDERS (if applicable): The appropriate individuals as listed in Section 2 shall administer medication as follows:

Name of Medication: ____________________________________________________________________

Timing/Dosage: ________________________________________________________________________

Possible side effects: ___________________________________________________________________

Duration/End date: _____________________________________________________________________

*This order is valid for the above determined duration but no longer than the ____________ school year.*

I hereby certify that the above information is accurate. I further certify that the above named pupil is physically fit to attend school and is free of contagious disease. Finally, I certify that if this medication was not administered during school hours, the above named pupil would not be able to attend school.

__________________________________________________________ ______________________________

**SIGNATURE OF PHYSICIAN/HCP** **DATE**

**OFFICIAL STAMP OF PHYSICIAN/HCP**
(including address, phone and fax number)

## STAFFORD TOWNSHIP SCHOOL DISTRICT
## PARENT PERMISSION TO ADMINISTER MEDICATION AT SCHOOL

### SECTION 2 - TO BE COMPLETED BY PARENT/GUARDIAN

I, _________________________________ (parent/guardian), hereby give permission to the SCHOOL NURSE to administer the above medication to ________________________________ (pupil's name).

By signing this form, I acknowledge and agree:

1) That I have received and carefully reviewed Policy 5330 and Regulation 5330;
2) That I have been informed in writing that the Stafford Township School District shall incur no liability as a result of any injury arising from the administration of this medication to my child.
3) That I shall indemnify and hold harmless the District and its employees or agents against any injury or claims that may arise as a result of the administration of this medication.
4) That I am aware that if I desire to withdraw permission for any designee to administer medication, I must do so in writing.

___________________________________________________ ____________________________

**SIGNATURE OF PARENT/GUARDIAN** **DATE**

*Once completed, please make arrangements with the school nurse to drop off this form and your child's medication. The school nurse shall then review this form and forward to the Principal for completion. Please be advised that students cannot self-carry medication into school for delivery.*

### SECTION 3 – AUTHORIZATION - TO BE COMPLETED BY DISTRICT PERSONNEL

By signing this form, I acknowledge that I have received and reviewed all sections of this form and give my approval for administration of medication as set forth herein.

___________________________________________________ ____________________________

**SIGNATURE OF SCHOOL PRINCIPAL** **DATE**

___________________________________________________ ____________________________

**SIGNATURE OF SCHOOL NURSE** **DATE**

*Once completed, the school nurse shall forward appropriate information to the Superintendent's office.*