

Plumstead Christian School

MEDICATION DISPENSING FORM

Medication will be administered to students during school hours only when such medication is needed by the student to remain in school and administration is required during school hours. **No medication will be administered to any student without proper completion of the Medication Dispensing Form.** The form should also be used for non-prescription drugs when prescribed by a physician or dentist.

All medication to be administered by school personnel must be delivered in **the original and properly labeled container** to the school nurse, principal, or the principal's designee along with the Medication Dispensing Form. Prescription and non-prescription medicine will be locked in the nurse's office. **All controlled medications must be delivered to the school health office by an adult counted and recorded on the student's medication log.**

In the absence of the school nurse or health room associate, the principal or the principal's designee will administer the medication. In cases where the Medication Dispensing Form is not available and administration of the medication is necessary, registered nurses may obtain verbal orders from the attending physician by phone. Such verbal orders may be documented on the Medication Dispensing Form by the school nurse. In order for the medication to be administered the following day, a signed Medication Dispensing Form must be received from the parent or guardian. Failure of the parent/guardian to provide documentation will require the parent/guardian to be present in school to administer the medication personally.

TO BE COMPLETED BY PHYSICIAN/DENTIST

Student's Name: _____ Age: _____ Grade: _____ School: _____

Name of Medication: _____ Specific Dosage: _____ Frequency: _____

Special Considerations: _____

Reason for Medication: _____

Effective Dates: _____ From: _____ To: _____

It is my understanding that the employees of the Central Bucks School District charged with the administration of this treatment/procedure during school hours rely on directions contained in this document. I further certify that I am the physician or dentist who prescribed the treatment and that the student named above is under my supervision as a patient.

Signature of Physician/Dentist: _____

Printed Name of Physician/Dentist: _____

Address: _____

Telephone: _____ Fax: _____ Date: _____

TO BE COMPLETED BY PARENT/GUARDIAN

As parent/guardian of the above named student, I hereby request that the treatment described above be administered to my child and release Central Bucks School District and its employees from liability for any damages my child may suffer as a result of this request.

Signature of Parent or Guardian: _____

Home Telephone: _____ Work Telephone: _____