CLELIAN HEIGHTS SCHOOL
135 CLELIAN HEIGHTS LANE
GREENSBURG, PA 15601
(724) 837-8120 x 1143

IN ACCORDANCE WITH HEMPFIELD AREA SCHOOL DISTRICT MEDICATION ADMINISTRATION POLICY

PERMISSION TO ADMINISTER AND MAINTAIN MEDICATION

STUDENT'S NAME: _____DATE OF BIRTH: _____AGE: _____

NAME OF MEDICATION: _____REASON PRESCRIBED: _____

DOSE: _____AT(TIME) _____ FOR: ___DAYS ____MONTHS ___INDEFINITELY

SPECIAL ADMINISTRATION INSTRUCTIONS: _____

PARENT/GUARDIAN MUST PROVIDE ANY FOOD/FOOD ITEMS IF REQUIRED FOR MEDICATION ADMINISTRATION

PRESCRIBING PHYSICIAN: _____PHONE #: _____

THE SCHOOL NURSE MAY CONTACT THE PHYSICIAN AND OR PHARMACY

NAME OF PHARMACY: _____PHONE #: _____

I will take full responsibility for the prescribed medication which is to be given.

NAME OF PARENT OR GUARDIAN: _____
PLEASE PRINT

SIGNATURE OF PARENT OR GUARDIAN: _____

DATE: _____ PHONE #: _____ _____
HOME CELL

Medication must be brought to school in the original container appropriately labeled with the date, student's name, name of medication, dosage, and the time to be given.
The "TIME to be given MUST be on the prescription bottle. The nurse cannot accept "at lunch time" or "in the morning" or "twice a day". Please ask the prescribing physician to indicate a time for the medication to be administered.

- A written order from the physician ***must*** accompany ***all*** prescription ***and*** over-the-counter (OTC) non-prescription medications to be administered at school.
- A written note from the physician ***must*** accompany ***any*** change or discontinuation in the medication prescription.