

NESHANNOCK TOWNSHIP SCHOOL DISTRICT  
3832 MITCHELL ROAD  
NEW CASTLE, PA 16105  
PHONE: (724) 652-8709

**Administration of Medication Clarification**

In compliance with the Neshannock Township School District's new medication administration policy and the Pennsylvania Department of Health's Guidelines for Medication Administration, there are changes of which parents need to be aware. The following guidelines are provided to clarify Neshannock Township School District's procedures in regard to dispensing prescription and non-prescription medication in school. Medication (over the counter and/or prescription) will only be administered if the required form is completed by both the student's parent and doctor.

**Medication Authorization:**

- If you want your child to receive medication during school hours, the appropriate medication form titled *Medication Administration Consent and Licensed Prescriber Order* must be completed by the parent AND licensed prescriber.
- Medications will not be given unless the *Medication Administration Consent and Licensed Prescriber Order form* is completed by both the parent and doctor. This includes both over-the-counter (Claritin, Mucinex, Dimetapp etc.) and prescription (antibiotics, steroids, eye drops etc.) medications. The new form is attached and can be found on our school website.

**Delivery:**

- Any prescription or over-the-counter medication to be given during school hours at the Neshannock Township School District must be delivered directly to the school nurse by the parent/guardian or by another adult designated by the parent/guardian. If you need to make arrangements for the transportation of your child's medication, please feel free to call the nurse in your child's building.
- The medication must be brought to the school in the original and properly labeled container indicating the student's name, dosage, and time of administration. The parent or guardian assumes full responsibility for any medication sent to school.

**Other:**

- Please do not bring a full prescription to school, only the amount of pills or measured liquid that is needed to be administered at school. The district will not store more than a thirty day supply of an individual student's medication. Refrigeration is available. Ask your pharmacist to provide you with a second labeled bottle for you to separate the medication. This will eliminate the day-to-day transportation of medication.
- Standing orders such as pain relief medication, gastrointestinal medication, and decongestants will be administered to students as pre-approved by the parent on the emergency card and authorized by the school physician.
- Asthma inhalers, Epi-pens, and medications for low blood sugar may be carried by the student upon the completion of the proper forms by the parent/guardian and physician.

Thank you for your cooperation,  
School Health Services  
Neshannock Township School District

August 2014

**Medication Administration Consent And  
Licensed Prescriber Order**

**Neshannock Township School District**

Student Name: \_\_\_\_\_ Date/Time: \_\_\_\_\_

School: \_\_\_\_\_ Teacher/Grade: \_\_\_\_\_

In accordance with school policy, medication(s) should be given at home before and/or after school. However, when this is not possible, prior to receiving the medication at school, each student must provide the school nurse with a *Medication Administration Consent* form signed by the student's parent/guardian and a *Medication Order* from a licensed prescriber. All medications must be in an original prescription bottle/container from a pharmacy.

**Parent/Guardian Consent:**

I give my permission for my child, \_\_\_\_\_, to receive the following medication by a licensed prescriber during the school day. I understand that the medications will be given by school health personnel according to my child's licensed prescriber's directions.

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian name printed: \_\_\_\_\_ Phone: \_\_\_\_\_

**Licensed Prescriber Medication Order:**

Patient's name: \_\_\_\_\_ Date: \_\_\_\_\_

Name of medication: \_\_\_\_\_

Route and dosage: \_\_\_\_\_

Time of administration: \_\_\_\_\_

Directions: \_\_\_\_\_

Discontinuation date: \_\_\_\_\_

Allergies: \_\_\_\_\_

Licensed prescriber signature: \_\_\_\_\_

Licensed prescriber name printed: \_\_\_\_\_ Phone: \_\_\_\_\_