New Hope-Solebury School District
School Health Services

MEDICATION/TREATMENT GUIDELINES

- The Medication/Treatment Dispensing Form on the reverse side must be completed by both the prescribing licensed provider (physician, dentist) and the parent/guardian for all medication (prescription and over the counter) that must be administered during the school day. No medication will be administered without the proper completion of the Medication/Treatment dispensing form.

- Medication will be administered to a student during school hours only when such medication is needed by the student to remain in school and administration is required during school hours. If possible, prescribing licensed providers should time administration of medication before or after school.

- Prescription medication as well as non-prescription medications must be delivered to the school nurse or principal in the original labeled pharmacy container or box by a parent/guardian.

- In cases where the Medication/Treatment Dispensing Form is not available and administration of the medication is necessary, nurses may obtain verbal orders from the attending physician by phone for the first day only. In order for the medication to be administered the following day, a signed Medication/Treatment Dispensing Form must be received.

- Failure to provide documentation will require the parent/guardian to be present in school to administer the medication personally.

- Under no circumstances will the first dose of an antibiotic be given at school due to the risk of an adverse reaction.

- In accordance with Act 187 of the school code and NHSD procedures, students requiring rescue inhalers and Epi-pens may be permitted to carry and self administer medications with a completed Self Administration of Medication form and a competency assessment by the school nurse.

New Hope-Solebury School District
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MEDICATION/TREATMENT DISPENSING FORM

The following to be completed by the licensed prescriber

Patient's name ____ **Date** ___________________

Name of medication ____

Dosage ________________ **Time to be given** ________________ **Route** ________________

Reason for Medication/Treatment____

Directions ____

Effective dates _________________**to**_________________

Allergies ____

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

Licensed Prescriber signature ____

Licensed Prescriber name printed ___________________________ **Phone:** _________________

Parent/Guardian Consent

I give my permission for my child, ____, to receive the following medication ordered by a licensed prescriber during the school day and release the New Hope-Solebury School District and its employees from liability for any damages my child may suffer as a result of this request. 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:** _________________