Pennridge School District
School Health Services

MEDICATION PERMISSION 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 Permission Form. Pennridge School District will only give those medications that are FDA approved.** This form needs to be used for both prescription and non-prescription drugs (over the counter products).

All medication to be administered by school personnel must be delivered by an adult to the Health Office in **the original, properly labeled container,** given to the school nurse, principal, or the principal's designee along with the Medication Permission Form. Prescription and non-prescription medicine will be locked in the nurse's office**. In accordance with state law**, **MEDICATIONS** can only be returned to the parent or legal guardian
Students are not permitted to carry any medication with them in school,
Exception – Properly labeled inhalers (with Physician approval), and Epi-pens.

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 Pennridge School District charged with the administration of this treatment/procedure during school hours rely on the directions contained in this document. I further certify that I am the physician or dentist who prescribed the medication/ 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 the Pennridge 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: _____ Cell Number: _____

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