MANHEIM CENTRAL SCHOOL DISTRICT

281 White Oak Road
Manheim, Pennsylvania 17545
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Health Services

Carol Festa, CSN	Angela Forwood, CSN	Doreen Willey, CSN	Brandi Hess, LPN	Randi Myer, LPN
High School	Middle School	H.C. Burgard Elementary	Doe Run Elementary	Stiegel Elementary
V: 664-8422	V: 664-1700	V: 665-8900	V: 665-8854	V: 665-8804
F: 664-8420	F: 664-1859	F: 665-8909	F: 665-8860	F: 665-8819

The PA State Law and the medication policy of Manheim Central School District requires the **written order** of a physician/dentist/CRNP/PA's **and** the **written authorization** of the parent/guardian for a nurse to administer **both over the counter (OTC) or prescription medications**. Medications must be in the original container for OTC; or in a properly labeled, pharmacy-prepared container with the name of the **student**, name of the **drug**, **dosage**, **method of administration**, **time** of the dose, date of original prescription and the name of the prescribing licensed health care provider.

PHYSICIAN/DENTIST/CRNP/PA ORDER

Name of Student _____ Date _____

Address _____ DOB_____

Condition for which the drug is needed to be administered during school hours _____

Drug (name, dose and method administration) _____

Time of administration _____

Date to begin administration at school _____

Relevant side effects to be observed, if any _____

Inhaler is to be kept with student _____ Yes* _____ No

*Inhalers that are prescribed by a physician may be kept with the student **only** when this form is completed and returned to the school nurse. The completed form will be retained on file in the health room. A new form must be completed for each school year.

Physician Signature _____ **Date** _____

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AUTHORIZATION BY PARENT/GUARDIAN OF THE ABOVE MEDICATION BY SCHOOL PERSONNEL:

To School Personnel:
I request that the above medication, ordered by the physician/dentist/PRNP/PA for my child _____, Be administered by school personnel. I understand that I must supply the school with the prescribed medication **in the original container dispensed** and properly labeled by a physician or pharmacist and will provide no more than a 45 school day supply. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.

Parent/Guardian Signature _____ **Date** _____

Relationship to Child _____ **Phone**_____