

**BIG BEAVER FALLS AREA SCHOOL DISTRICT
SCHOOL HEALTH SERVICES**

Central Elementary
Susan Swanson, RN, CSN, BSN
724-843-3420, ext. 6124

Big Beaver Elementary
Lisa Green, RN, CSN, MSN
724-843-3420, ext. 5201

Middle School and High School
Daya Lindsey, RN
724-843-3420
AM – High School, ext. 1311
PM – Middle School, ext. 1224

ADMINISTERING PRESCRIBED AND OVER THE COUNTER MEDICATION TO STUDENTS

In general, medication will not be given during the school day. If, however, it is essential, then the parent should bring to the nurse's office (in a pharmacy issued container labeled with the student's name) one month's supply of the prescribed medication. This must be accompanied by the form below, completed and signed by the physician and parent.

(Name of Child) _____
(Name of Medication)

(Purpose of Medication)

(Date Prescription Begins) _____
(Date Prescription is to Cease)

(Dosage) _____
(Time of Dosage)

(Special Instructions, if any, i.e. pills crushed, with water, etc.)

(Possible Reaction)

(Procedure to follow if a reaction should occur)

(Person to Contact) _____
(Phone Number)

Does the Medication require refrigeration? Yes No

If medication is an inhaler or epi-pen, is the student permitted to carry it in school and self-administer? Yes No
By answering yes to the above statement, the physician is stating that the child has been instructed on how to use the inhaler or epi-pen and is capable of self-administering.

I do hereby release, discharge and hold harmless, the Big Beaver Falls Area School District, its agents, employees and school nurse, from any and all liability and claim, whatsoever, for the administration of the above medication to my child/student should there develop an allergic or other reaction to the medication.

I understand that if my child is carrying and self-administering an inhaler or epi-pen, the school district bears no responsibility for insuring that the medication is taken.

(Name of Physician, Printed) _____
(Name of Parent/Guardian, Printed)

(Signature of Physician) _____
(Signature of Parent/Guardian)

Please return this form with the medication.

(Date)

(Phone)

(Date)

Please return this form with the medication.

Revised 2014