Clairton City School District

School Health Services
501 Waddell Avenue
Clairton, PA 15025
(412) 233-9200 ext. 1124
Fax: (412) 233-4590

Student _____ Birthdate _____ Grade/Homeroom_____

In accordance with school policy, medication(s) should be given at home before and/or after school. 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 parent/guardian and a **Medication Order** from a licensed physician, dentist, CRNP or PA. ***Prescription medication must be in the original prescription container from a pharmacy. Over the counter medications must be sent in the manufacturer's original container.***

Parental Directive for Administration of Medication

I, the parent/guardian of (student) _____, have provided the school with the necessary forms from my child's doctor to have the medication administered during the school day or on a school sponsored field trip. I understand that the Clairton City School District makes an effort to ensure that only licensed health care professionals administer the medications at school. However, I also acknowledge and understand that there may not be a licensed health care worker in my child's school at all times during the school day. I hereby release, discharge and hold harmless the School District, its agents and employees, from liability for any act or omission committed in connection with administration of my child's prescribed medication.

Parent/Guardian Signature: _____ Date: _____

For Inhaler, Epinephrine auto-injector, Insulin, or emergency medications only: I give permission for my child to carry and self-administer the emergency medication in school and on field trips as directed by the Licensed Prescriber on the reverse side of this form. I acknowledge that the School District is not responsible for ensuring that my child's self-administered medication is taken.

Parent/Guardian Signature: _____ _Date: _____

Print Parent/Guardian Name _____Phone _____

THE DOCTOR/HEALTH CARE PROVIDER MUST COMPLETE THE SECTION ON THE REVERSE SIDE.

Clairton City School District
School Health Services

THIS SECTION MUST BE COMPLETED BY THE HEALTH CARE PROVIDER

Child's Name: _____ D.O.B. _____

Medication: _____Dose: _____

Time & Frequency: _____ Route: _____

Give Daily? Yes _____ No_____ P.R.N. Indications: _____

D/C Date (limit one school year): _____

Allergies: _____

Precautions: _____

Inhaler: The child was instructed and is able to demonstrate correct inhaler use. He or she is responsible to carry the inhaler for independent self-administration. ◯ Yes ◯ No

Epinephrine auto-injector: The child was instructed and is able to demonstrate correct Epinephrine auto-injector use. He or she is responsible to carry the auto-injector for independent self-admiminstration. ◯ Yes ◯ No

Give Epinephrine auto-injector immediately after ingestion of allergen or bee sting?

◯ Yes ◯ No

If NO: List symptoms for Antihistamine: _____

List symptoms for Epinephrine auto-injector: _____

Insulin: The child was instructed and is able to demonstrate correct insulin use. He or she is responsible for independent self-administration of insulin. ◯ Yes ◯ No

Health Care Provider Signature _____ Date _____

Print Health Care Provider Name _____ Phone _____