



POTTSTOWN SCHOOL DISTRICT

ADMINISTRATION BLDG. • Beech & Penn Streets • PO Box 779 • Pottstown PA 19464-0779 • (610)323-8200 • FAX(610)326-6540

POLICY FOR ADMINISTRATION OF MEDICATION

Dear Parent/Guardian:

According to the State Health Code, including the State Board of Nurse Examiners, the school nurse may not administer any prescription medication without a written order from your child's physician indicating the name of the medication, the dosage, the reason it is being given, and the time to administer it in school. Your signature is also required.

Also, the school nurse is not permitted to administer non-prescription medications (over-the-counter or patent medications) without a physician's written permission. The name of the medication, the dosage, the reason, and the time to be administered must be included in the permission statement. Your signature is also required.

In order for the school nurse to administer prescription medications, the Pottstown School District requests that you ask your physician to complete the enclosed form. In the event your child needs non-prescription medications, fill in the name of the medications on the enclosed form and ask your doctor to sign it. Have your child return the form to the school nurse. Medication must be labeled properly, including the date, the name of the student, the name of the medication, the dosage, the reason it is being given, and the time to administer it.

The school nurse will be glad to administer medications in keeping with the State of Pennsylvania regulations upon you and your physician's completion of the "Permit to Administer Medication" form. Phone permission is not acceptable. Thank you for your cooperation in this important matter.

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NON-PRESCRIPTION PERMIT TO ADMINISTER MEDICATIONS (Signed permit good for current school year)

Student Name: _____ Room/Section: _____
Name of Non-Prescription Medication: _____
Strength of Medication: _____ Amount to be Given: _____
Dates to be Given: _____ Time to be Given: _____
Reason for Medication: _____

Signature of Parent/Guardian Phone Number Date

Signature of Physician Phone Number Date

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PRESCRIPTION PERMIT TO ADMINISTER MEDICATIONS (Signed permit good for current school year)

Student Name: _____ Room/Section: _____
Name of Prescription Medication: _____
Strength of Medication: _____ Amount to be Given: _____
Dates to be Given: _____ Time to be Given: _____
Reason for Medication: _____

Signature of Parent/Guardian Phone Number Date

Signature of Physician Phone Number Date