

FRAZIER SCHOOL DISTRICT
OFFICE OF THE SCHOOL NURSE
142 CONSTITUTION STREET
PERRYOPOLIS, PA 15473
PHONE: 724-736-9507 FAX: 724-736-0688

Dear Parent/Guardian,

The Frazier School District recognizes that it is sometimes necessary for students to take medications during the school day in order to maintain their health and promote academic success. When medication is required during school hours, **either prescription or over-the-counter** (including cough drops), parents/guardians must do ALL of the following:

*Deliver medication to school nurse in original, labeled pharmacy or manufacturer's container.

*Complete, sign and date a Permission to Administer Medication form.
A new form must be completed each school year.

*Obtain physician's written order to administer medication including medication name, dose, route, time, adverse side effects, duration of order, and signature This is required for over-the-counter medications, also. **A new form must be completed each school year.**

*Give initial dose of medication at home so parents/guardians are aware of any side effects, sensitivities, or allergies

Students who need to carry inhalers or epinephrine auto-injectors with them throughout the school day **MUST** have a Doctor's written order and parent signature on file in the Nurse's office.

Please have the attached copy of the required Permission to Administer Medication form **completed, signed, and returned** to the school nurses. You may bring the form to the office of your child's school or mail or fax it to the above address or fax number.

Thank you for your time and cooperation in helping to promote and maintain the health and safety of our children.

Sincerely,
Frazier School Nurses

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PERMISSION TO ADMINISTER MEDICATION

This is to certify that _____, _____
(Name of Student) (Grade)
must receive the following medication during school hours:

- *Diagnosis: _____
- *Name of Medication: _____
- *Dose: _____
- *Route: _____
- *Frequency and Times: _____
- *Duration of Order: _____
- *Possible Side Effects: _____

- * This student is capable of self-administration [] Yes [] No
 - * Inhaler []
 - * Epinephrine Auto-Injector []

I do hereby release, discharge and hold harmless the Frazier School District, its agents and employees, from any and all liability and claim whatsoever for the administration of the above medication to this child should a reaction develop from the medication. Frazier School District bears no responsibility for ensuring that self-administered medication is taken.

Physician Signature: _____

Date: _____

Name of Prescribing Physician: _____

Address: _____

Telephone Number: _____

Parent/Guardian Signature: _____

Date: _____

Name of Parent/Guardian: _____

Address: _____

Telephone Number: _____