NAZARETH AREA SCHOOL DISTRICT
SCHOOL HEALTH SERVICES

(For confidentiality, fax machines are located in the School Nurse Offices)
School Nurse Office – Nazareth Area High School – Fax: 610-849-0863
School Nurse Office – Nazareth Area Middle School – Fax: 610-759-3262
School Nurse Office – Nazareth Area Intermediate School – Fax: 484-292-1113
School Nurse Office – Kenneth N. Butz, Jr. Elementary School – Fax: 610-849-0866
School Nurse Office – Lower Nazareth Elementary – Fax: 610-849-0865
School Nurse Office – Shafer Elementary – Fax: 610-849-0862

Administering Medication to Students

Continued concern for the health and safety of your child in the Nazareth Area School District has prompted a change in the medication distribution policy and procedure.

If your child needs to take medicine in school, prescription or *over-the-counter, the procedure is as follows:
As a provided service, medication including over-the-counter medication will be administered to students in the regular school setting and only in circumstances when the child's health may be jeopardized without it.

Written authorization, signed by the physician, psychiatrist, or dentist (original or by fax) **and** the parent, legal guardian, or emancipated student must be provided for each separate prescription or medication being administered to each student. If dosage is changed, new written authorization is required. Authorization will terminate with the expiration date of the prescription or at the end of the school year, whichever occurs first. If the medication is discontinued, the parent or legal guardian must notify the school nurse in writing.

MEDICATION MUST BE DELIVERED TO THE SCHOOL NURSE BY THE PARENT, LEGAL GUARDIAN, AUTHORIZED ADULT DESIGNEE OR EMANCIPATED STUDENT IN THE ORIGINAL MEDICATION CONTAINER.
STUDENTS ARE NOT TO HAVE MEDICATION IN THEIR POSSESSION AT ANY TIME PER SCHOOL DISTRICT DRUG AND ALCOHOL POLICY EXCEPT PHYSICIAN AUTHORIZED SELF-ADMINISTERED EMERGENCY MEDICATIONS.

It will be the responsibility of the parent, legal guardian, or emancipated student to make arrangements for administration of medication during activities away from school.

Medication sent to school in violation of this policy will not be administered to a student.

*Over-the-counter: ***Does not*** apply to cough drops, but does include aspirin, Tylenol, herbal supplements, Ibuprofen, and antacids, etc., in which case a one school year standing order from the child's personal physician will be accepted.

ATTENTION: STUDENTS REQUIRING AN EPI-PEN or AVUI-Q

The nurse MUST have this form completed and the necessary medication
THE FIRST DAY OF THE SCHOOL YEAR

OVER

NAZARETH AREA SCHOOL DISTRICT
<u>AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS</u>

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The Nazareth Area School District requires a **<u>physician's/psychiatrist's/dentist's</u>** written order and a **<u>parent's/legal guardian's/emancipated student's</u>** authorization for the school nurse, or in her/his absence the designee, to administer medications. Medication must be in original medication container.

<u>PHYSICIAN'S/PSYCHIATRIST'S/DENTIST'S ORDER</u>

__________________________________ ________ __________________________

Student's Name *Grade* *Date of Birth*

The student should receive the following medication during school hours in order to maintain sufficient health and participation in the school program.

CONDITION FOR WHICH MEDICATION IS BEING ADMINISTERED: __________________________________

SELF-ADMINISTRATION OF Inhalant, Enzyme or Epi-Pen/Benadryl MEDICATION (Please circle one)

The above named student has demonstrated the ability to self-administer the physician-prescribed emergency medication, as indicated by the following criteria:

1. Respond to and visually recognize his/her name.
2. Identify his/her medication.
3. Demonstrate the proper technique for self-administering his/her medication
4. Knowledge of medication side effects and agrees to report any side effects to the Nurse

Do you recommend that the student:

Self-administer and carry in school?	YES _____	NO _____
Only carry in school?	YES _____	NO _____

MEDICATION: ______________________________________ DOSAGE: ____________________________

TIME: _________________ POSSIBLE SIDE EFFECTS: ____

PHYSICIAN'S/PSYCHIATRIST'S/DENTIST'S NAME-*<u>PRINTED</u>*: ____

ADDRESS: ____ PHONE: ______________________________

____ ___________________________________

Signature of Physician/Psychiatrist/Dentist *Date*

<u>AUTHORIZATION BY PARENT/LEGAL GUARDIAN/EMANCIPATED STUDENT</u>

Name of Student _____________________________ is requested to receive the above medication during school hours in order to maintain sufficient health and participation in the school program.

We (I) do hereby grant permission for school staff to communicate directly with the physician/psychiatrist/dentist named above.

We (I) do hereby release, discharge, and hold harmless NASD, its agents, and employees from any and all liability and claims whatsoever in connection with administration of the above medication to my child.

We (I) have read and agree to follow the procedures set forth by the policy and procedure.

______________________________________ ________________ ____

Signature of Parent/Legal Guardian Date Daytime Phone

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