

**UNIFORM GUIDELINES FOR THE ADMINISTRATION  
OF MEDICATION DURING SCHOOL HOURS**

The Mount Carmel Area School District recognizes that parents have the primary responsibility for the health of their children. Although the district strongly recommends that medication be given in the home, we realize that the health of some children requires that they receive medication while in school.

Parents should confer with the child's physician to arrange medication time intervals to avoid school hours whenever possible. When medications absolutely must be given during hours, certain procedures must be followed:

- 1) The physician must complete and sign Section 1 of this form.
- 2) The parents must complete and sign Section 2 of this form.
- 3) Any medication to be given during school hours must be delivered to the school nurse, by the parent. The medication must be brought to school in the original pharmaceutically dispensed and properly labeled container. The physician must complete Section 1 and the parent must complete Section 2 before medication/treatment can be administered.

**Section 1 (Physician)**

1. Student's Name \_\_\_\_\_
2. Name of medication \_\_\_\_\_
3. Dosage and Time \_\_\_\_\_
4. Necessity for the medication during the school day \_\_\_\_\_  
\_\_\_\_\_
5. Type of disease or illness involved \_\_\_\_\_  
\_\_\_\_\_
6. Benefits of medication \_\_\_\_\_  
\_\_\_\_\_
7. Any side effects \_\_\_\_\_  
\_\_\_\_\_
8. For Inhaled Medications:  
\_\_\_\_\_ I have instructed this student in the proper way to use his/her medications. It is my professional opinion that this student should be allowed to carry and use this medication by him/her self.  
\_\_\_\_\_ It is my professional opinion that this student should not carry his/her inhaled medication by him/her self.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Doctor's Signature)

\_\_\_\_\_  
(Phone #)

**Section 2 (Parent)**

I, the undersigned parent of the above-mentioned child, hereby give permission for the school nurse or her designee to administer the medication indicated above. I will not hold any person or group liable if the directions of the doctor are followed, and hereby release the Mount Carmel Area School District from any liability arising out of providing the treatment and/or medication indicated. I also give the school nurse my permission to contact the doctor if necessary to clarify questions concerning this treatment/medication.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Parent's Signature)

\_\_\_\_\_  
(Phone #)

NO MEDICATION/TREATMENT WILL BE ADMINISTERED UNLESS THIS PROCEDURE IS FOLLOWED. THANK YOU.