**Student Medications at School**

In order for your student to receive prescription medication at school, this packet must be completed and returned to the School Nurse.

1. Medication Policy (*provided below)*
2. Consent for Administration and Medication Order
   * *The top half is to be completed by guardians. This gives consent for the Nurse to administer medications.*
   * *The bottom half is to be completed by physician, outlining medication specifications.*
3. Authorization for Exchange of Information
   * *This allows the Nurse to communicate with the prescribing provider in case of emergency or to assist with med management.*

**Provident’s Medication Policy**

Student Use of Medication at School

The parent/guardian must also provide the prescription or written order of the prescribing physician. The prescription or written order must include the purpose of the medication, dosage, time at which or special circumstances under which the medication is to be administered, length of period for which medication is required and possible side effects of medication. All medications must be presented in the original prescription bottle. **Medications must be transported to the school by the parent.** *Please do not send students to school with medications.* This puts the student in a position of violating the school’s drug policy. Note: No Expired Medications Will Be Accepted.

Contact the School Nurse with any further questions at 412-709-5160, ext. 106 or [jmueller2@providentcharterschool.org](mailto:jmueller2@providentcharterschool.org).

Sincerely,

Julia Mueller, RN, MSN



**AUTHORIZATION FOR EXCHANGE OF INFORMATION**

I authorize the following organizations Provident Charter School and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to release/exchange information and share communication in verbal, written, and/or electronic form regarding:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

(Student Name) (Date of Birth)

This information is to be used in the planning of an appropriate educational program for the student. The confidentiality of the information received will be protected by the State and Federal guidelines regarding the collection, maintenance and dissemination of student records (Family Education Rights and Privacy Act of 1974). Information for release includes the following: (Please Check All That Apply)

\_\_\_\_\_ Grades Report Card \_\_\_\_\_ Psychological/Psychoeducational/

\_\_\_\_\_ Standardized Test Results Neuropsychological Evaluation

\_\_\_\_\_ Health/Immunization Records \_\_\_\_\_ Psychiatric Evaluation

\_\_\_\_\_ Attendance Records \_\_\_\_\_ Special Education Data (ER, IEP)

\_\_\_\_\_ Transcripts/Credit Data \_\_\_\_\_ Gifted Education Data (if separate

\_\_\_\_\_ Discipline Records from special education)

\_\_\_\_\_ Other, Please Specify: \_\_\_\_\_ Medication Management

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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(Outside Provider’s Name) (Outside Provider’s Phone #)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Parent/Legal Guardian Signature) (Date)

Release is valid for one year from date above

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Telephone)

Medication Policy

By signing you are agreeing to Provident’s Medication guidelines as stated on page 1 of the Medication Packet.

Name (printed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_