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 schoolnurse@providentcharterschool.org.

Sincerely,
Aubrey Ferreira, RN, BSN

PROVIDENT CHARTER SCHOOL

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
_____ Standardized Test Results

_____ Health/Immunization Records

_____ Attendance Records

_____ Transcripts/Credit Data
_____ Discipline Records

Other, Please Specify:

_____

_____

_____ Psychological/Psychoeducational/ Neuropsychological Evaluation

_____ Psychiatric Evaluation

_____ Special Education Data (ER, IEP)

_____ Gifted Education Data (if separate from special education)

_____ Medication Management

_____ _____
(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_____

Pittsburgh Public Schools
Expect great things.

PITTSBURGH PUBLIC SCHOOLS – HEALTH SERVICES
CONSENT FOR ADMINISTRATION OF MEDICATION AND MEDICATION ORDER

Dear Health Care Provider: Your patient's legal guardian has requested that a PRESCRIBED MEDICATION or an OVER THE COUNTER (OTC) MEDICATION be given to their child at school. Most medications should be taken at home unless there is a specific lunchtime dose, or the prescribed medication is needed in the event of an emergency or prescribed PRN medication like epi-pen, inhaler, migraine medication, etc.

ALL MEDICATIONS TAKEN AT SCHOOL MUST HAVE PARENTAL CONSENT FOR ADMINISTRATION, A MEDICAL ORDER AND BE IN THE ORIGINAL PHARMACY LABELED CONTAINER. A PHOTO OF THE STUDENT WILL BE TAKEN AND ATTACHED TO THE STUDENT'S MEDICINE LOG.

TO BE COMPLETED BY PARENT (PLEASE PRINT CLEARLY) ENTER SCHOOL YEAR_____

	MONTH	DAY	YEAR		
STUDENT'S NAME	DOB			SCHOOL	GR

I understand fully the directions that have been given to the school nurse or other licensed school health staff by my child's physician. I agree to permit the school nurse or other licensed school health staff to administer the medication as directed.

I hereby authorize the School District Health Staff to contact the medical provider (named below) regarding this medication and to release information regarding my child (named above) to said provider. I hereby authorize the medical provider to release information about my child and this medication to the School District Health Staff regarding any medical concerns about this medication order.

I understand that to protect the limited confidentiality of medical information, my agreement to release information is necessary and that this permission is limited for the purpose and to the person or entity mentioned above and will be in effect for the current school year. I understand that the disclosed information will be kept confidential and the releasing facility will not be responsible for re-disclosure of the information. I also understand that this consent is revocable with written, or if necessary, verbal notice, except to the extent that action has been taken in reliance thereon.

X_____ **X**_____ **X**_____
SIGNATURE - PARENT/GUARDIAN/LEGAL REP. PRINT - PARENT/GUARDIAN/LEGAL REP. DATE

BEST PHONE:_____ ALT. PHONE:_____.

TO BE COMPLETED BY PHYSICIAN (PLEASE PRINT CLEARLY)

Diagnosis:		Length of treatment:
Medication:		
Dose, Route, Schedule:		
PRN (indications and timing):		
List serious reactions to the medication:		
List appropriate response to above reactions:		
X	**X**	**X**
PHYSICIAN'S SIGNATURE	PRINT NAME	DATE
ADDRESS & ZIP		PHONE
		FAX