

# MIFFLIN COUNTY SCHOOL DISTRICT

201 Eighth Street – Highland Park, Lewistown, Pennsylvania 17044

## PERMISSION TO GIVE / TO KEEP / TO CARRY MEDICATIONS AT SCHOOL

To be completed each school year and/or when student's medication changes

PARENTS ARE RESPONSIBLE FOR INFORMING THE SCHOOL NURSE OF ANY CHANGES IN MEDICATION, DOSAGE, OR IF THE MEDICATION IS DISCONTINUED.

CHILD'S NAME \_\_\_\_\_ GRADE \_\_\_\_\_ SCHOOL \_\_\_\_\_  
HOME ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

### PHYSICIAN'S PERMISSION (or attach Physician's Statement)

The child named above is being treated by me for (Diagnosis) \_\_\_\_\_

and must/may take (Medication) \_\_\_\_\_

Dosage \_\_\_\_\_

**Time** \_\_\_ noon/lunch

\_\_\_ as needed

\_\_\_ every 4 hrs p.m.

\_\_\_ not more than once per day

\_\_\_ other (specify time) \_\_\_\_\_

**For** \_\_\_ days

\_\_\_ remainder of the school year

\_\_\_ until medication is discontinued/changed

\_\_\_ must carry on person

\_\_\_ other (specify) \_\_\_\_\_

This child is able to self-administer his/her inhaler: yes / no (please circle one).

*I certify that I am the health care provider who prescribed the medication and that the student named above is my patient for diagnosis and treatment. I understand that the Mifflin County School District and its employees will be distributing medication; they will be relying upon the directions I have set forth above.*

Print or stamp name and phone number

Signature \_\_\_\_\_ Date \_\_\_\_\_

M.D., D.O., P.A., C.R.N.P.

### PARENT/GUARDIAN'S PERMISSION

*My child must/may take the medication specified above. The school nurse or designated school official has my permission to distribute this medication to my child. As parents/guardians of the above named child I/we release the Mifflin County School District and its employees or agents from any and all liability for any injuries my child may suffer as a result of this request.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

### NURSE'S PERMISSION

Permission is granted to give this medication as directed above.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Medication should be sent to school in an original container which is properly labeled.

Students should bring the medication and the permission slip to the nurse, teacher, or secretary.

The student is not to carry medication in school unless an exception is authorized.

**Failure to properly complete this form will result in the school personnel of the Mifflin County School district not being able to distribute medication to the student.**

A copy of the completed permission shall be forwarded to the principal.