PA LEADERSHIP CHARTER SCHOOL
MEDICATION AUTHORIZATION FORM

PARENT/GUARDIAN: As per the PA Department of Health and the PA Department of Education, all prescription and over-the-counter medications must be accompanied by a written physician order **and** parent/guardian permission. Please complete **both** sections of this form if it is necessary for your child to receive a medication during school hours or during a school sponsored activity i.e. field trips. **Each medication requires a separate form completed by your child's doctor and yourself each school year or whenever changes in medication or dosage occurs**. All medications, prescription or OTC, must be in their original packaging with label, child's name and directions intact. Medications must be delivered by the parent/guardian to Health Services or the person in authority.

Authorization and Instructions for Medication Administration during School or School Sponsored Events

Student Name _____ **Date**_____

DOB _____ **M** ___ **F**___ **Grade** _____ **Attends PALCS: Cyber** _____**CPFA**_____ **USP** _____

Diagnosis _____ **Medication Allergies** _____
Medication _____ **Dose** _____ **Route** _____
Time/Frequency _____
Duration for medication: Entire school year _____ **OR from the dates**: ___/___/20___ to___/___/20__
Precautions and adverse reactions _____
Emergency response for serious reaction _____

Inhaler: The child was instructed and is able to demonstrate correct inhaler use.
He/she is responsible and will carry the inhaler for independent self-administration. (Circle one) **YES NO N/A**

EpiPen: The child was instructed and is able to demonstrate correct EpiPen use.
He/she is responsible and will carry the EpiPen for independent self-administration. (Circle one) **YES NO N/A**

Insulin: The child was instructed and is able to demonstrate correct Insulin use.
He/she is responsible and will carry the Insulin for independent self-administration. (Circle one) **YES NO N/A**

PHYSICIAN/CRNP/PA/ or Dentist Signature **Date** **Phone**

PARENT/GUARDIAN AUTHORIZATION

I request that my child take the medication as directed on this form. It is the student's responsibility for coming to the nurse or person in charge to receive medication. I acknowledge that the school nurse may not in every instance administer the medication. I release and indemnify PALCS, its officers, agents and employees from any and all liability resulting from medication administration. I also authorize, as needed, the sharing of information related to my child's health between the school nurse, the health care provider, appropriate staff or activity leader.

Students who carry and self-administer an asthma inhaler, EpiPen or Insulin in school must be able to demonstrate the following:

1. Proper and correct use/administration of the medication in the dose, time and frequency as prescribed on this form
2. Notify the school nurse immediately following each use of the medication
3. Keep the medication in a specified location and will not share medication with other students

If at any time the student is unable to demonstrate correct use of the medication as prescribed above, shows signs of irresponsible behavior or if there is a safety risk, the school nurse or adult in authority has the right to confiscate the medication and withdraw the privilege to self-administer. I acknowledge that the school has no responsibility for ensuring that self-administered medications are taken.

FOR INHALER, EPI PEN, and INSULIN ONLY: I request that the school comply with the prescription above that permits my child to carry and self-administer the medication. (Circle one) **YES NO N/A**

Parent/Guardian Signature **Date** **Phone**

School Nurse Authorization:_____ **Date:**_____