

QUAKERTOWN COMMUNITY SCHOOL DISTRICT

MEDICATION DURING SCHOOL HOURS

Please make every effort to plan a medication schedule so that all medications, whenever possible, are taken at home, rather than at school. Please discourage your child from using non-prescribed "over-the-counter" medications during school hours. The school district realizes, however, that at times your child may need to take a medication during school hours in order to maintain health and attend school.

You, the parent, **MUST** complete the following:

Child's Full Name _____

School _____ Grade _____

I request that employees of the Quakertown Community School District supervise my child's taking of the medication listed below. I release the school district and its employees from liability for any damages my child may suffer as a result of this request. I understand that this medication may not be shared with another student and that such an act is a violation of the school district's drug and alcohol policy. I give my permission for the School Nurse to speak with the physician regarding this medication prescription.

Signature of Parent or Guardian

Date

Prescription and non-prescription medications sent to school must always be in the original container **and stored in the nurse's office, unless the physician indicates otherwise**. Prescription medications must have the physician's printed directions on the container. This form may also be used for non-prescription drugs, such as Tylenol, when recommended by a physician or dentist.

Child's Full Name _____		
Medication Prescribed _____		
Reason or Condition _____		
Prescribed Dosage _____		
Time Schedule _____		
I certify that it is imperative that this medication be taken during school hours.		
(<input type="checkbox"/>) It is medically necessary for this child to carry this medication with him/her during the school day. (Please initial if applicable.)		
_____ Physician's Signature	_____ Telephone #	_____ Date