Conestoga Valley School District
2110 Horseshoe Road
Lancaster, PA 17601

PARENTAL REQUEST AND PHYSICIAN'S ORDER FOR MEDICATION

(For students who require daily or emergency medication)

Parents have the primary responsibility for the health of their child. As a general rule, and if at all possible, medication should be taken at home.

If parents wish to delegate some part of their responsibility to the school, the following will apply:

- Parents and physician will be required to complete the form below.
- School nurse or designee will dispense medication according to the physician's written orders.
- Labeled medication will be stored in a secure place for the period indicated on the physician's order.

At the end of school, the parent is expected to pick up unused medication. Medication not picked up by the last day of school will be destroyed.

TO BE COMPLETED BY PARENT/GUARDIAN:

Child's Name _____ Birthdate_____ School_____

I request that medication for my child (named above) be stored or administered as indicated in the physician's order below. I am aware that non-medical personnel may be administering this medication to my child. We hereby release the Conestoga Valley School District and all of its employees of and from any and all liability in law for damages either we or our child may suffer as a result of this request.

Parent/Guardian Signature_____ Date_____

Home Telephone_____ Work Telephone_____

TO BE COMPLETED BY PHYSICIAN:

IT IS NECESSARY THAT THE NAMED CHILD RECEIVE THE FOLLOWING MEDICATION AT THE TIMES STATED BELOW. PLEASE STORE AND ADMINISTER THE FOLLOWING AS DIRECTED BELOW:

Name and Form of Medication:_____ Dosage:_____ Time(s) to be given:_____

Route of Administration:_____

Other Specific Directions:_____

Purpose of Medication and/or Diagnosis:_____

Side Effects to Watch:_____

Duration of Order:_____

_____	_____	_____	_____
Telephone	Physician's Name(Type)	Physician's Signature	Date

PERMISSION FOR SELF CARRY OF MEDICATION

I recognize that school policy requires all prescription medication to be stored in the nurse's office and to be dispensed only by nurse or designee. Because of the nature of this medication, I request that my child be permitted to carry the medication at all times and to use as directed by the physician. To be granted such permission, I shall file this completed form with the nurse and I will assumed all responsibility for any problems resulting from granting this permission. This responsibility includes, but is not limited to, misuse, loss and/or sharing the medication with others.

_____ _____

Parent Signature Date