STUDENT'S NAME:

LAST: _____ FIRST: _____

DATE OF BIRTH: _____ GRADE: _____ ROOM: _____

DUQUESNE CITY SCHOOL DISTRICT
REQUEST FOR ADMINISTRATION OF MEDICATION
DURING SCHOOL HOURS

Phone: 412-466-9600, ext. 7009 Fax: 412-469-3625

The Duquesne City School District requests that medication be given at home during non-school hours. However, it recognizes that sometimes it is essential for medication to be administered at school. *Any medication to be administered during school hours must include both physician and parent signature.* No "**over- the-counter**" medication will be given to any student without an order from a physician, along with signatures from the physician and parent. All **PRESCRIPTION** medication must be in a pharmacy labeled container. The label must include the name and phone number of the pharmacy, the pupil's name, the physician's name, the medication, the currently prescribed dose, time of administration and the Rx numbers. All **NONPRESCRIPTION** medication must be in an original container.

All medications shall be brought to the school by the parent and kept in the nurse's office. If this is not possible, the pharmacy-labeled container or original manufacturer's package must be sent to school in a sealed envelope with a note signed by the parent/guardian stating the number of tablets being sent to school.

PHYSICIAN'S NAME (please print): _____

PHYSICIAN'S PHONE: _____ FAX: _____

DIAGNOSIS (Unless Confidential): _____

NAME OF MEDICINE: _____

PRESCRIBED DOSAGE: _____

TIME SCHEDULE: _____

LENGTH OF TIME (DAYS / WEEKS): _____

POTENTIAL REACTION SIDE EFFECTS: _____

EMERGENCY RESPONSE: _____

Is child qualified and able to self-administer? _____ YES _____ NO

PHYSICIAN'S SIGNATURE: _____ DATE: _____

TO BE COMPLETED BY PARENT / GUARDIAN

To: Building Principal, Please comply with the attached/above written instructions from our physician, certified registered nurse practitioner or physician assistant regarding the administration of medication for our child. As the parent / guardian of above named student, I relieve the school district and its employees of any responsibility for the benefits or consequences of the prescribed medication. I acknowledge that the school is not responsible for ensuring the medication is taken.

PARENT / GUARDIAN SIGNATURE: _____ DATE: _____

PARENT / GUARDIAN TELEPHONE: _____