INDIAN VALLEY
Nursery School
&
Kindergarten

## Medication Guidelines

Dear Parent/Guardian,

The PA Department of Health and National Association of School Nurses have specific guidelines for medication administration in the school setting. To administer medications, the following procedures must be implemented:

1. The ordering physician/prescriber must provide a written order listing the drug name, dosage and time the medication is to be administered. When the medication dosage is changed, the ordering physician/prescriber must provide a new written order.
2. The parent or guardian will need to fill out a Medication Administration Consent form. If there is a change in medication dosage, then a new form will need to be filled out.
3. The medication must be in an original prescription bottle and have the label of the pharmacy that fills the prescription.
4. The Medication Administration Consent form/Licensed Prescriber Order form will need to be filled out and signed by parent/guardian AND ordering physician/prescriber. Please contact the IVNS School Nurse for form access.

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**Medication Administration Consent**
**Licensed Prescriber Order**

**Student Name:**_____ **Teacher:** _____

Ideally, all prescribed medication(s), should be given at home prior to school. However, if it is absolutely necessary for your child to be given prescription medication during school hours, the following form must be completed in full and returned to the IVNS School Nurse along with the prescribed medication. **The medication must be in an original prescription bottle and have the label of the pharmacy that fills the prescription**.

**Parent/Guardian Consent:**

I, _____, give permission for my child, _____, to receive the following prescribed medication(s) as ordered by a physician/prescriber during school hours. I understand the medication(s) will be given by IVNS School Nurse or appointed IVNS staff, in the event the School Nurse is not available at the time the medication(s) are to be given.

Parent/Guardian signature:_____ Date: _____

************The following portion is to be filled out by Ordering Physician/Prescriber only************

**Licensed Prescriber Medication Order:**

Patient Name: _____ Date: _____

Name of medication : _____

Directions: _____

Discontinuation date (if applicable): _____

Diagnosis/Reason: _____

Allergies: _____

Licensed Prescriber Signature: _____ Date: _____

Licensed Prescriber Name Printed: _____ Phone: _____