SUSQUEHANNA WALDORF SCHOOL

Student Medication Administration Form

10/2024

Before any medication, prescribed or over-the-counter, may be administered during school hours, the School Board requires a **signed written order from the prescribing medical care provider and the written request of the parent/guardian**, giving permission for such administration. Exceptions are as-needed medications that are stocked by the school, for which only parent/guardian consent is required (that consent is separate from this document). Please refer to the All-School Handbook for the complete policy.

PRESCRIBER ORDER

Student's Name:_____ **DOB:**_____ **Grade:**_____

Medication	Dosage	Route	Admin. Time	Duration	Diagnosis	Self Admin. Y/N (Epi & Inhalers Only)**

1. I verify that the above plan has been prescribed by me, the student's health care provider, and should be carried out by the school the student attends.
2. **FOR SELF-ADMINISTERED EPINEPHRINE AUTO-INJECTORS AND ASTHMA INHALERS:** By answering "yes," I verify that in my opinion it is necessary for the student to carry this medication during the school day AND I have evaluated the student and found them to be capable of self-administration.

Licensed Prescriber's Signature: _____

Printed Name: _____

Date: _____

Time: _____

PARENT/GUARDIAN CONSENT

All medication must be brought to school by a parent, guardian, or designated adult. **Medication must be counted with the Administrative Coordinator at the time of drop off.**
Prescription medication must be in the original container labeled with:

- Student's name & date of birth
- Medication name, dosage & route of administration
- Frequency of administration
- Name of the prescriber

Over-the-counter medications must be in the original container. **Tablets should be split at home to coincide with the ordered dosage.**
Medications not meeting the listed criteria will not be accepted..

Unused and expired medications should be collected from the school by a parent, guardian, or other trusted adult. **Any uncollected medication will be destroyed at the end of the school year.**

By signing below, you agree to the following AND you verify the quantity of medication delivered to the school:

1. I request that the above medication(s) be administered during school hours as ordered by the student's licensed prescriber. I am aware that the Administrative Coordinator or other school staff who will be administering the medication(s) are not licensed nursing professionals.
2. I release school personnel from liability in the event of adverse reactions resulting from medication administration or lack thereof.
3. I give permission for the Administrative Coordinator or other school staff to communicate with the student's teachers about the student's health condition and the action of the medication.
5. I am aware that if the student is permitted to self -administer their medication they must report to the Administrative Coordinator after the administration. If not, the student may lose their privilege of self-administration.
7. I understand a new medication form must be completed with any prescribed changes to the medication and at the beginning of every new school year.
8. I understand it is my responsibility to communicate any changes in my student's medical condition or changes.

MEDICATION:_____ **QUANTITY:**_____

Parent/Guardian's Signature: _____ Printed Name: _____ Date: _____ Time: _____

Admin Coordinator's Signature: _____ Printed Name: _____ Date: _____ Time: _____

MEDICATION DISPOSAL

☐ **Medication returned to parent/guardian**

Parent/Guardian's Signature: _____ Printed Name: _____ Date: _____ Time: _____

Admin Coordinator's Signature: _____ Printed Name: _____ Date: _____ Time: _____

☐ **Medication destroyed**

Admin Coordinator's Signature: _____ Printed Name: _____ Date: _____ Time: _____