

WESTERN WAYNE SCHOOL DISTRICT

Request for Administration of Medication During School Hours

EverGreen Elementary

Ph: 1-800-321-9973

Fax: 570-341-1220

C. Davis, CSN

C. Salak, RN

R.D. Wilson Elementary

Ph: 1-800-321-9973

Fax: 570-341-1224

M. Shelp, CSN

WW Middle School

Ph: 1-800-321-9973

Fax: 570-341-1223

G. Mitchell, CSN

M.K. Bifano, CRNP

WW High School

Ph: 1-800-321-9973

Fax: 570-341-1222

D. Johnson, CSN

Dear Health Care Provider,

It is the policy of Western Wayne to request that medication be given at home whenever possible. However, if it is essential that the student receive medication at school, please provide the following information. Also, please note where indicated below if the student may *independently self-administer* rescue inhalers or Epi-Pens.

Physician's Permission

Date _____

I want _____ to receive the following medication(s) during school hours:

	Medication #1	Medication#2	Medication #3
Name of Medication			
Dosage			
Route of Administration			
Time to be Given			
Duration of Order			

Condition/Diagnosis _____

Yes No Is the student capable of *supervised self-administration*?**Yes No** Has the student demonstrated the capability for *independent self-administration* and responsible behavior regarding the use of a rescue inhaler or Epi-Pen?

(The student must notify the school nurse following independent use of the medication, but the school bears no responsibility for ensuring that the medication is taken as ordered.)

PHYSICIAN'S SIGNATURE _____ **PHONE** _____**FAX** _____

Parent/Guardian Permission

Permission is given for my child to receive the medication(s) as ordered above during school hours. I do hereby release, discharge and hold harmless the Western Wayne School District, its agents and employees, from any and all liability and claims whatsoever for the administration of the above medication(s) to my child.

Parent/Guardian's Signature _____ **Date** _____