

EASTERN LANCASTER COUNTY SCHOOL DISTRICT
New Holland, Pennsylvania 17557

Dear Parent or Guardian:

Your school district recognizes that to insure good health and best educational conditions, it is sometimes necessary for pupils to receive medication during school hours. **School board policy limits the giving of medications in school to either prescription medicines or over-the-counter medicine necessary for ensuring the student's health.** If medicine must be given during school hours, the following procedure must be followed.

The medication, in its original container, labeled with a prescription by a pharmacist or a physician, must be accompanied by this completed permission slip from the parent or guardian and the physician. Any medication which comes under the law of controlled substances (such as Ritalin) must be **delivered by the parent** to the school nurse. **Please DO NOT send unlabeled containers to school.** All medications are kept in the nurse's office. Refrigeration is available when required. Students are expected to come to the health room at the appropriate time to take their medicine. Students who need to self-administer medications (such as inhalers) are permitted to do so with the school nurse's permission and are required to report each self-administered dose to the school nurse.

The taking of medications is a serious health concern, and your cooperation in following the above guidelines to insure your child's health is appreciated. Please complete and return this form when your child needs to take medication at school.

Sincerely,
Gwen Clevenger, R.N.
Beth Fulmer, R.N.
Jacqueline Hollinger, R.N.
Joy Hoover, R.N.
School Nurses

I hereby grant permission for the nurse, or any person authorized by the school, to administer the medication listed below. If a medical necessity arises, the nurse may contact the prescribing professional to discuss this medication.

Name of Child _____ Grade _____ Teacher _____

Name of Medication _____

Reason for medication _____

Possible Side Effects _____

Time to be given _____ Amount to be given _____

Additional instructions _____

Date _____

Date _____

Signature of Parent

Signature of Physician

For Health Room Use Only

Signature/Initials:

Date:	Date:	Date:	Date:	Date:	Date:
Date:	Date:	Date:	Date:	Date:	Date:

In computer: student record