LANCASTER COUNTY
CAREER & TECHNOLOGY
CENTER

Permission for first aid nurse or student to self-administer prescription medication at school and during field trips.

To be completed each school year and when student's medication changes.

Parent/Guardian is responsible for informing the first aid nurse of any changes in medication, dosage, or if the medication is discontinued.

Student's Name: _____ Grade: _____

Home Street Address: _____ Phone: _____

City, State, Zip: _____

Physician's Permission (or attach Physician's Statement)

The student (name above) is being treated by me for (diagnosis) _____

and must/may take (medication) _____ dosage _____

Time:
_____ noon/lunch
_____ as needed
_____ every 4 hours
_____ not more than once per day
_____ other (specify time) _____

For:
_____ days
_____ remainder of the current school year
_____ other (specify) _____
_____

Potential serious reactions or side effects: _____

Emergency response if dose is ineffective: _____

The student is able to self-administer this medication without assistance from a licensed medical professional:

(Please circle one) Yes No

The student is able to self-administer his/her inhaler, EpiPen, or diabetes medication:

(If applicable, please circle one) Yes No

I certify that I am the health care provider who prescribed the medication and that the student named above is my patient for diagnosis and treatment. I understand the Lancaster County Career & Technology Center will be relying upon the directions I have set forth above.

Physician Name: _____ Physician Phone Number: _____

Signature: _____ Date: _____

Parent/Guardian Permission

My child must/may take the medication specified above. I therefore request the Center first aid nurse to give my child the above medication while in school. If self-administration of the medication is authorized, I authorize a responsible adult, other than the first aid nurse, to give this medication to my child for self-administration. I do hereby release, discharge and hold harmless, the Center, its agents and employees, from any and all liability and claim whatsoever for the administration of the above medication to my child or the benefits or consequences of the prescribed medication. In addition, the Center bears no responsibility for ensuring that the medication is taken. I acknowledge that I have read and understand the information page attached to this document concerning the use of medication at Lancaster County Career & Technology Center.

Signature: _____ Date: _____

Asthma Inhaler/EpiPen/Diabetes Medication Usage

(only to be signed if student is to self-carry/administer asthma inhaler, EpiPen, or diabetes medication)

I hereby acknowledge that my child has permission to carry his/her asthma inhaler, EpiPen, or diabetes medication to use in case of an emergency. I acknowledge that the Center is not responsible for ensuring the medication is taken. I also relieve the school and its employees of responsibility for the benefits or consequences of the prescribed medicine.

Signature: _____ Date: _____