MEDICATION POLICY AND PERMISSION FORM COATESVILLE AREA SCHOOL DISTRICT

PLEASE RETURN THIS COMPLETED FORM TO THE SCHOOL NURSE IF YOUR STUDENT NEEDS TO BRING MEDICATION FROM HOME

PLEASE USE A SEPARATE FORM FOR EACH MEDICATION REQUIRED

Student name:		School:
School year:	Grade:	Homeroom/Advisory:
Medication Policy #210:		
parent/guardian or by anothe	r adult designated by th	ce, or the main office if the nurse is in another building, by the he parent/guardian. All medication shall be stored in the original binet designated for storage of medication."
Licensed Prescriber Med	lication Order:	
Name of Medication:		
Dose/Time(s) to be Admir	nistered:	
Special Instructions:		
nhalers or Epipens ONLY	: Does this student h	nave permission to carry? YES NO
Licensed Prescriber Signa	ture:	
Licensed Prescriber Name	Printed:	
License Number:		Date:
Parent/Guardian Conser	nt:	
	hat the medications v	ceive the following mediation by a licensed prescriber duri will be given by the school health personnel according to m
Inhalers or Epipens ONLY	: Does this student l	have permission to carry? YES NO
		MONSTRATE TO NURSE THAT THEY ARE USING PRO USE IN ORDER TO CARRY THEIR EPIPEN/INHALER.
Parent/Guardian Signature	::	Date:
		Phone: