WEST MIFFLIN AREA SCHOOL DISTRICT
91 COMMONWEALTH AVENUE
WEST MIFFLIN PA. 15122

ONLY COMPLETE IF MEDICATIONS NEED ADMINISTERED DURING SCHOOL HOURS

Dear Parent/Guardian,

Administration of medicine is a responsibility the West Mifflin Area School District views with considerable concern. In order to conform to State guidelines, **no medication can be dispensed during school hours without a physician first completing the attached form. This includes over-the counter medication** such as, Tylenol, Motrin, antacids, cough, cold, allergy medications, etc. A separate form is needed for each medication. Also, students **are not** permitted to carry medication to, from, or during school hours unless a physician specifically states it is medically necessary.

You will find the necessary form on the reverse side of this letter. After it is completed and signed by you and the prescribing physician and returned to the school, the medication **must** be brought to school by the parent or guardian. **Over-the-counter medication must be in its original bottle, and prescription medication must be properly labeled by a registered pharmacist and brought to school in its current bottle.**

The following is a list of the fax numbers for each of the district's schools to assist you and/or your physician in efficiently forwarding the necessary information:

CLARA BARTON MIDDLE SCHOOL	(412) 469-3357 (412) 466-0836	HOMEVILLE HIGH SCHOOL	(412) 461-5465 (412) 896-7906

Thank you for your cooperation.

Sincerely,

West Mifflin Area School District Nursing Staff

WEST MIFFLIN AREA SCHOOL DISTRICT
HEALTH SERVICE DEPARTMENT
PHYSICIAN'S INSTRUCTIONS FOR ADMINISTERING MEDICATION
DURING SCHOOL HOURS

NAME OF STUDENT: _____
DATE OF BIRTH: ____/____/____ GRADE: _____ DATE OF ORDER: ___/____/____
DIAGNOSIS: _____
DOSAGE: _____ FREQUENCY: _____

- **INHALER**: MAY THE STUDENT CARRY IT WITH THEM? _____
HAS BEEN INSTRUCTED AND SHOWS COMPETENCE FOR SELF-ADMINISTATION: _____

- **EPI-PEN:** MAY THE STUDENT CARRY IT WITH THEM? _____
HAS BEEN INSTRUCTED AND SHOWS COMPETENCE FOR SELF-ADMINISTATION: _____

HOW LONG DO YOU EXPECT MEDICATION TO BE GIVEN? _____
CAN A REACTION BE EXPECTED? _____
IF SO, PLEASE DESCRIBE & ANY EMERGENCY ACTION THAT MAY BE REQUIRED
_____
_____
_____

SIGNATURE OF PHYSICIAN: _____

PHYSICIAN'S NAME (PRINT): _____

OFFICE AND PHONE NUMBER: _____ # _____

PARENTAL REQUEST FOR ADMINISTERING MEDICATION DURING SCHOOL HOURS

I, _____ fully understand the directions that have been given to the school by the physician and agree to permit school personnel to administer the medication to my son/daughter _____, and/or have my child self-administer according to the directions given by the physician listed above.

I hereby release West Mifflin Area School District, or any of its employees from any and all liability incidental to providing services as herein requested including that they bear no responsibility for ensuring that the medication is taken if my child is permitted to self-administer.

END OF SCHOOL YEAR, I WOULD LIKE THE REMAINING MEDICINE:
- **DISCARDED: _____ WILL PICK UP: _____**

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: ____/ ____/ _____

PHONE #: HOME#: _____ CELL#: _____ WORK #: _____