****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  (412) 469-3357
- Middle School  (412) 466-0836
- Homeville  (412) 461-5465
- High School  (412) 896-7906

Thank you for your cooperation.

Sincerely,

West Mifflin Area School District Nursing Staff
WEST MIFLIN 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 __________________________________________________
Name of medication ________________________________________ Route __________________
Dosage ____________________________________________________ Frequency ____________________

* If an inhaler, may the student carry it with them? __________
**Has been instructed and shows competence for self-administration ______

* If an Epi-pen, may the student carry it with them? __________
**Has been instructed and shows competence for self-administration ______

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 ______________________________________________________________

________________________________________ Date _____ / _____ / _____
Signature of physician

Physician's name (please 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 the 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.

At end of school year, I would like remaining medicine: *discarded [ ] *kept in school [ ]

Signature of parent/guardian __________________________________ Date _____ / _____ / _____

Phone Number: Home # __________________________ Cell# __________________________ Work #: __________________________