CENTRAL BUCK SCHOOL DISTRICT
20 WELDEN DRIVE, DOYLESTOWN, Pennsylvania - 267-893-2000

MEDICATION DISPENSING FORM

- ***All medication, whether prescription or over-the-counter, must be kept in the school health room and be accompanied by a healthcare provider's order. The protocol for students requiring medication in school is as follows:***
  - The health care provider must complete the top part of the form; parents/guardians must sign the bottom section, giving your permission to administer the medication in school.
  - We will accept an order on a private prescription form attached to this page with parent/guardian signature in place.
  - ***Medication will not be administered to any student in school without completed orders in place. Failure to provide documentation will require the parent/guardian to be present in school to administer the medicine personally.***
  - Medications must be brought to school in the original labeled container and given to the school/staff nurse. **All controlled medications i.e. Ritalin, Concerta, Adderall must be delivered to the school nurse by an adult, counted and recorded on the student's medication log.**

TO BE COMPLETED BY PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN'S ASSISTANT/DENTIST

STUDENT'S NAME: _____ AGE: _____ GRADE: _____ SCHOOL: _____

NAME OF MEDICATION: _____ DOSAGE: _____ FREQUENCY: _____

SPECIAL CONSIDERATIONS: _____

REASON FOR MEDICATION: _____

EFFECTIVE DATES: FROM: _____ TO: _____

It is my understanding that the employees of the Central Bucks School District charged with the administration of this treatment/procedure during school hours rely on directions contained in this document. I further certify that I am the health care provider who prescribed the treatment and that the student named above is under my supervision as a patient.

SIGNATURE OF HEALTH CARE PROVIDER: _____

PRINTED NAME OF HEALTH CARE PROVIDER: _____

ADDRESS: _____

TELEPHONE: _____ FAX: _____ DATE: _____

TO BE COMPLETED BY PARENT/GUARDIAN

As the parent/guardian of the above named student, I hereby request that the treatment described above be administered to my child and release the Central Bucks School District and its employees from liability for any damages my child may suffer as a result of this request.

Signature of Parent/Guardian: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____