GREATER LATROBE SCHOOL DISTRICT

CENTRAL ADMINISTRATION BUILDING
1816 LINCOLN AVE * LATROBE, PA 15650
724-539-4200

Private Physician Request for Administration of Medication During School Hours

(PS-H-29 Rev 1/17)

Dear Physician:

The parent/guardian of _____ has requested that we supervise their child taking the medication listed below during school hours. It is our procedure to request that medication be taken prior to or after school hours whenever possible. If it is essential that the child receive the medication during school hours, please complete the following information.

ALL MEDICATION MUST BE SENT TO SCHOOL IN THE ORIGINAL PRESCRIPTION CONTAINER

Part 1: To be completed by Physician only.

NAME OF MEDICATION: _____

DIAGNOSIS OR REASON FOR MEDICATION ADMINISTRATION:

_____

DOSAGE: _____

TIME SCHEDULE FOR ADMINISTRATION: _____

DURATION OF MEDICATION ADMINISTRATION: _____

POSSIBLE SIDE EFFECTS OR CONTRAINDICATIONS: _____

_____

CURTAILMENT OF SPECIFIC SCHOOL ACTIVITY, IF APPLICABLE (SPORTS, SHOP, LAB, DRIVER'S TRAINING, ETC.):

_____

_____

FIELD TRIP (OUT-OF-SCHOOL EXPERIENCE) ORDERS (CHECK ALL THAT APPLY):

☐ MEDICATION TO BE GIVEN WITHIN _____ HOURS OF ABOVE TIME, ***BEFORE*** THE FIELD TRIP

☐ MEDICATION TO BE GIVEN WITHIN _____ HOURS OF ABOVE TIME, ***AFTER*** THE FIELD TRIP

☐ MEDICATION ***NOT TO BE GIVEN DAY OF FIELD TRIP*** IF THE PRESCRIBED SCHEDULE CAN NOT BE FOLLOWED

☐ A NURSE MUST ATTEND ALL OUT-OF-SCHOOL EXPERIENCES DUE TO THE ***SEVERE, LIFE-THREATENING*** NATURE OF THE STUDENT'S MEDICAL CONDITION OR THE ***NECESSITY*** FOR MEDICATION TO BE ADMINISTERED AT EXACTLY THE ABOVE PRESCRIBED TIME.

_____ _____

SIGNATURE OF PHYSICIAN DATE

Physician's Name _____

Physician's Address _____

Part 2: To be signed by parent/guardian.

I hereby give my permission for the school to supervise my child taking this medication, and I will take full responsibility for the prescribed medication which is to be taken during school hours.

_____ _____

SIGNATURE OF PARENT/GUARDIAN DATE