COLUMBIA-MONTOUR
Area Vocational-Technical School

5050 Sweppenheiser Dr. • Bloomsburg, PA 17815-8920 • www.cmvt.us • Ph: (570) 784-8040 • Fax: (570) 784-3565

Medication Administration/Self-Carry Form

HOW CAN A STUDENT TAKE MEDICATION IN SCHOOL?

- Prescription medication or other medications not routinely stocked in the nurse's office will **only be given by written direct order of a physician,** according to recommendations by the Pennsylvania Department of Health and school medication policy. Medications routinely stocked in the nurse's office that do not require a physician's order include Regular-strength Tylenol, Ibuprofen, antacids and anti-gas medications.
- The attached form must be completed by parent/guardian and family physician before any medicine will be administered. **A new form is needed at the beginning of each new school year and for each new medication order**. Forms can be accessed at the CMAVTS webpage at www.cmvt.us, go to forms tab, click on other forms here option and print or visit the nurse's office. Medication must be in an original bottle which includes the prescription name, number and date. ALL MEDICATIONS AND SUPPLIES MUST BE STORED IN THE NURSE'S OFFICE.
- Medicine will be given by the school nurse or licensed individual designated by the building administrator.
- IT IS A VIOLATION OF SCHOOL POLICY FOR A STUDENT TO CARRY MEDICATIONS ON HIM OR HERSELF unless it is an emergency medication such as an EpiPen or Asthma Inhaler. Self-carry emergency medication will only be permitted by physician orders.
- **Carrying medication without complying with the above information can result in disciplinary action. Upon non-completion of medical form medication will not be dispensed to students.**

BRINGING MEDICATION TO THE SCHOOL:

- Parent/guardian of students must bring medications and properly completed medication form to the nurse's office.
- Medications will be counted and signed in when brought to the school.

TAKING MEDICATION FROM THE SCHOOL:

- At end of designated time period of medication being administered stated by physician, all unused medication will be returned to the parent/guardian. Medication will be counted and signed for upon retrieval. If parent/guardian does not pick up medications after being notified, medications will be disposed of.

Medication should be given at home when possible. Note: medication policies are available for your review at the school should you have any questions or concerns.

PLEASE COMPLETE THE ATTACHED FORM AND RETURN IT TO THE NURSE'S OFFICE. MEDICATION CANNOT BE ADMINISTERED WITHOUT IT.

COLUMBIA-MONTOUR AREA VOACTIONAL TECHNICAL SCHOOL
5050 Sweppenheiser Drive, Bloombsurg, PA 17815
Nurse's Office Phone: (570) 784-8040, ext. 3328 Fax: 1 (570) 609-2568 or (570) 784-1401

PERMISSION TO GIVE/CARRY MEDICATION AT SCHOOL
To be completed each school year and/or when student's medication changes

STUDENTS'S NAME: _____ GRADE: _____ DATE: ___/___/_____

PHYSICIAN'S PERMISSION (or attach Physician's Complete Medication Order)

Diagnosis: _____ Name of medication: _____
Dose/Route: _____/_____ Time: _____ Frequency of use: _____

I certify that I am the health care provider who prescribed the medication and that the student named above is my patient for diagnosis and treatment. I understand that the Columbia-Montour Area Vocational Technical School and its employees will be distributing medication; they will be relying upon the directions I have set forth above.

Physician's Name (Please Print) _____

Physician Signature _____ Date __/__/____ Phone: _____

To be completed for EpiPen/Asthma Inhaler/Insulin usage

To be completed by physician
___ I have instructed the above listed student in the proper way to use this medication. It is my professional opinion that he/she be allowed to carry and self-administer this medication without supervision.
___ It is my professional opinion that above listed student should not carry and self-administer this emergency medication. The medication should be kept in the health room and administered by the nurse.

Physician Signature _____ Date __/__/____

SELF CARRY ONLY: To be completed by parent/guardian
I give permission for my child_____ to carry and use the emergency medication described. I understand he/she must follow the rules listed. I will notify the school nurse of changes in medication or my child's condition.

Parent/Guardian Signature _____ Date __/__/____

SELF CARRY ONLY: To be completed by student
1. I agree to never share my emergency medication with another person.
2. I agree to notify the school nurse immediately following each occurrence of self-administration of medication.
3. I agree to report to the school nurse if self-administration of asthma inhaler is ineffective in managing symptoms.
4. I agree to responsibly and appropriately carry and use this medication.

Student Signature _____ Date __/__/____

I understand that I am responsible for informing the school nurse of any changes in medication, dosage, or discontinuation. I request licensed personnel to give my child the above medication during the school day. I do hereby release, discharge and hold harmless, the school district, its agents and employees from any and all liability and claim whatsoever for the administration of the above medication to my child should there develop a reaction from the medication. I acknowledge that the school is not responsible for the ensuring the medication is taken. I also relieve the school and its employees of responsibility for the benefits or consequences of the prescribed medication.

Parent/Guardian Signature _____ Date __/__/____