ELIZABETH FORWARD School District

401 Rock Run Road, Elizabeth, PA 15037

Dr. Bart Rocco
Superintendent

Dear Parents/Guardian,

Administration of medicine is a responsibility the Elizabeth Forward 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, 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.

After the attached form is completed and signed by you and the prescribing physician and returned to the school nurse, 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 list of ***fax numbers*** will assist you and your physician in efficiently forwarding any necessary information to your child's school nurse.

Elizabeth Forward High School	412.384.2030
Elizabeth Forward Middle School	412.751.6669
Central Elementary	412.751.0692
Greenock Elementary	412.751.3818
Mt. Vernon Elementary	412.896.2390
Wm. Penn Elementary	412.384.4311

Thank you for your cooperation.

Sincerely,

Elizabeth Forward School District Nursing Staff

ELIZABETH FORWARD School District
401 Rock Run Road, Elizabeth, PA 15037

Health Services Department
Physician's Instructions for Administering Medication During School Hours

(Please Print)

Name of Student _____

Date of Birth ____/____/____ Child's Social Security # ____/____/____

Address _____ School _____

_____ Grade/Homeroom _____

Diagnosis _____ Date of Order ____/____/____

Name of Medication _____

Dosage _____ Route _____ Frequency _____

- If an inhaler, may the student carry it with him/her? _____
- If an epi-pen, may the student carry it with him/her? _____

How long do you expect the medication to be given? _____

Can a reaction be expected? _____ If so, please describe _____

_____

Signature of Physician _____ Date _____

Physician's Name (Please print) _____

Office location _____ Phone number _____

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 _____, according to the directions given by the physician listed above.

I hereby release the Elizabeth Forward School District, or any of its employees from any and all liability incidental to providing services as herein requested.

Signature of Parent/Guardian _____ Date _____

Phone Numbers – Home _____ Work _____ Cell _____