Central York School District
YORK, PENNSYLVANIA
SCHOOL HEALTH PROGRAM

PHYSICIAN COMPLETES THIS PART:

This completed form MUST accompany ALL MEDICATIONS (prescription, non-prescription, and herbal remedies) to be given at school.

I have prescribed for _____
(NAME of CHILD) (DOB) (GRADE/TEACHER)

_____ to be administered at school at
(NAME OF MEDICATION) (DOSAGE)

_____ for _____.
(TIME OF DAY) (APPROXIMATE LENGTH of TIME)

Diagnosis/Condition being treated: _____.

Specific instructions: _____.
****This medication may be withheld if student is attending an off campus activity.****
YES/NO

Students with written physician permission may carry inhalers and/or epipens. The school nurse will meet with these individuals to discuss further policies regarding carrying inhalers and/or epipens.
****This student may carry and self-administer inhaler and/or epipen. The student has been taught and demonstrates appropriate technique.**** **YES/NO**

Physician Name _____ / _____
(SIGNATURE) (PRINT NAME)

Date of order _____Physician phone # _____

PARENT / GUARDIAN COMPLETES THIS PART:

I give my consent for the school nurse or nurse/health assistant (RN or LPN) to administer the medication listed above to my child.

AND

I understand that only emergency, life-saving medications will be sent with my child's teacher on field trips (i.e. epipens and inhalers).

DATE _____ PARENT SIGNATURE _____