East Stroudsburg Area School District
Prescribing Health Care Provider Authorization for
Medication Administration During School Hours

The East Stroudsburg Area School District, in compliance with the Pennsylvania Department of Health and Pennsylvania Department of Education, has established the following medication policy:

- Medications, including over the counter medications, will **ONLY** be administered during school hours with **written authorization** from the prescribing health care provider and **written permission** from the parent/guardian.
- All medications **must be in the original container** with **current orders for the student** secured to the container.
- **All medications must be brought to the nurse's office for storage.**
- The student is responsible to report to the nurse at the appropriate time for his/her medication to be given.
- Medication must be administered by the School Nurse with the exception of asthma inhalers /Epinephrine auto injectors with self carry/administration authorization.
- Students who choose to carry and self-administer asthma inhaler/Epinephrine auto injector in the school setting **must** have a signed physician's order specifying that the student is responsible and capable of self-administration and has permission to carry and self-administer the medication.
- Students who carry their own inhaler/Epinephrine auto injector **must** have a second inhaler/Epinephrine auto injector in the nurse's office.
- Students who have medication of any kind on their person or with their belongings without the appropriate current self-carry/administration authorization are in violation of the school district drug and alcohol policy and may be subject to disciplinary action.
- Medication to be administered by parent/designated person on a field trip will be supplied by parent.
- Only emergency medications with self carry orders and medications necessary for the management of chronic health conditions will be sent on field trips.
- Medication orders are in effect for the current school year and must be renewed annually

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Student_____ **DOB**_____ **Grade/HR** _____

Diagnosis _____

Medication _____

Dosage _____

Time or indications for administration_____

Duration of medication administration order _____

Possible Side effects/conditions of medication _____

PHCP: PLEASE INITIAL THE APPROPRIATE SELECTION BELOW REGARDING SELF ADMINISTRATION OF INHALER/EPINEPHRINE AUTO INJECTOR **DURING SCHOOL HOURS:**

1. _____This student **DEMONSTRATES** the capability to carry and self administer the asthma inhaler/ Epinephrine auto injector as described above during school hours. (Extra properly labeled inhaler/Epinephrine auto injector must also be provided for nurse's office)
2. _____This student **DOES NOT DEMONSTRATE** the capability to carry and self-administer an asthma inhaler/Epinephrine auto injector during school hours.

PHCP: PLEASE INITIAL THE APPROPRIATE SELECTION BELOW FOR THE ADMINISTRATION OF EMERGENCY MEDICATIONS **ON FIELD TRIPS** (Inhalers, Epinephrine auto injectors):

During field trips the medication noted above will:

1. _____ Be self-administered by the student under the direct supervision of District staff member. The parent/guardian will provide the properly labeled medication in the original container with pharmacist instructions (Medications include Inhalers and Epinephrine auto injectors **ONLY**).

2. _____ Be administered by a parent/designated guardian accompanying the student on the trip. The parent/guardian will provide the medication for the trip.

PHCP: PLEASE INITIAL THE APPROPRIATE SELECTION BELOW FOR THE ADMINISTRATION OF DAILY MEDICATIONS **DURING FIELD TRIPS** (Medications permitted when failure to take such medicine would jeopardize the health of the student and/or the student would be unable to attend school if the medicine were not available during school hours **ONLY)**.

During field trips the medication noted above:

1. _____ Will be omitted on the day(s) of the field trip
2. _____ Will be administered upon return to the school
3. _____Will be administered by a parent/designated guardian accompanying the student on the trip.

PHCP Signature_____ **Date** _____

Address _____

PARENT/GUARDIAN: I authorize the East Stroudsburg Area School District to administer the above medication as prescribed by the PHCP. I do hereby release, discharge, and hold harmless the East Stroudsburg Area School District agents and employees from all liability and claim whatsoever for the administration/self-administration of the above medication to my child should they develop an adverse reaction from the medication.

Parent Signature_____ **Date** _____

Student Signature_____ **Date** _____