Pittsburgh Public Schools
Expect great things.

PITTSBURGH PUBLIC SCHOOLS – HEALTH SERVICES
CONSENT FOR ADMINISTRATION OF MEDICATION AND MEDICATION ORDER

Dear Health Care Provider: Your patient's legal guardian has requested that a PRESCRIBED MEDICATION or an OVER THE COUNTER (OTC) MEDICATION be given to their child at school. Most medications should be taken at home unless there is a specific lunchtime dose, or the prescribed medication is needed in the event of an emergency or prescribed PRN medication like epi-pen, inhaler, migraine medication, etc.

ALL MEDICATIONS TAKEN AT SCHOOL MUST HAVE PARENTAL CONSENT FOR ADMINISTRATION, A MEDICAL ORDER AND BE IN THE ORIGINAL PHARMACY LABELED CONTAINER. A PHOTO OF THE STUDENT WILL BE TAKEN AND ATTACHED TO THE STUDENT'S MEDICINE LOG.

TO BE COMPLETED BY PARENT (PLEASE PRINT CLEARLY) ENTER SCHOOL YEAR_____

	MONTH	DAY	YEAR		
STUDENT'S NAME	DOB			SCHOOL	GR

I understand fully the directions that have been given to the school nurse or other licensed school health staff by my child's physician. I agree to permit the school nurse or other licensed school health staff to administer the medication as directed.

I hereby authorize the School District Health Staff to contact the medical provider (named below) regarding this medication and to release information regarding my child (named above) to said provider. I hereby authorize the medical provider to release information about my child and this medication to the School District Health Staff regarding any medical concerns about this medication order.

I understand that to protect the limited confidentiality of medical information, my agreement to release information is necessary and that this permission is limited for the purpose and to the person or entity mentioned above and will be in effect for the current school year. I understand that the disclosed information will be kept confidential and the releasing facility will not be responsible for re-disclosure of the information. I also understand that this consent is revocable with written, or if necessary, verbal notice, except to the extent that action has been taken in reliance thereon.

X	X	X
SIGNATURE - PARENT/GUARDIAN/LEGAL REP.	PRINT - PARENT/GUARDIAN/LEGAL REP.	DATE

BEST PHONE: ALT. PHONE:

TO BE COMPLETED BY PHYSICIAN (PLEASE PRINT CLEARLY)

Diagnosis:	Length of treatment:
Medication:	
Dose, Route, Schedule:	
PRN (indications and timing):	
List serious reactions to the medication:	
List appropriate response to above reactions:	

X	X	X
PHYSICIAN'S SIGNATURE	PRINT NAME	DATE

	PHONE
ADDRESS & ZIP	FAX