

HOLY TRINITY SCHOOL

5720 Stuebenville Pike McKeesRocks, PA 15136 -1311 412-787-2656 FAX 412-787-9487

Mrs. Kimberly Stevenson
Principal

Dear Parents/Guardians:

Due to legal concerns, Holy Trinity School strongly recommends that medication be administered in the home. However, health situations do arise that require some students receive medication while in school. If your doctor determines it is necessary for your child to receive a medication during the school day, his/her approval and directions must be provided to the school. These same requirements also apply to any over the counter medications needed during school hours. Parents must sign an Indemnity Agreement form and follow the following instructions:

- All medications taken in school must be accompanied by a written physician's order and a written parent's permission.
- All medications must be in a prescription container labeled by the pharmacy or in an original container labeled by the manufacturer.
- An adult would need to bring the medication to the office. Students are not allowed to carry the medication to school.

Only medications which absolutely must be administered during school hours should be brought to the school for distribution by school personnel. For the safety of all our students please *never* send pills to school in baggies or lunchboxes.

Sincerely,

Montour School Nurses

**PARENT REQUEST FOR ADMINISTRATION OF MEDICATION
AND AGREEMENT OF RELEASE AND INDEMNITY**

We request that school personnel of Holy Trinity School administer medication per attached Physician's Form A to our child, _____ according to the direction of our attending physician. In making this request, we acknowledge that we have been advised that no physician will be present or available during the administration of medication, that a school nurse *will not be present* or available for this purpose, and that medication will be administered by a person with no medical training.

We acknowledge our awareness that the administration of medication under the anticipated circumstances might pose a substantial risk of injury to, including death of, our child. On behalf of ourselves and our child, we hereby exonerate, release and discharge Holy Trinity School and/or parish, the Roman Catholic Diocese of Pittsburgh, and their agents and employees, from any and all claims, causes or action and liability whatsoever in respect of any injury to, including death or, our child which may result at any time in the future by reason of any action taken, in good faith, pursuant to this request.

We further agree to indemnify, defend and hold harmless Holy Trinity School, parish, the Roman Catholic Diocese of Pittsburgh, and their agents and employees from any suit or proceeding brought to enforce any such claim, cause of action or liability. We enter into this agreement of release and indemnity voluntarily and without coercion for the purpose of inducing the employees of Holy Trinity School to administer medication to our child.

Signatures of all parents/guardians required.

Date

Parent/Guardian

Parent/Guardian

THIS DOCUMENT IS A CONTRACT WHICH AFFECTS YOU AND YOUR CHILD'S LEGAL RIGHTS. YOU SHOULD READ THIS DOCUMENT CAREFULLY. IF YOU DO NOT FULLY UNDERSTAND, YOU MAY SEEK INDEPENDENT LEGAL ADVICE BEFORE SIGNING THIS DOCUMENT.

**Medication Administration Consent And
Licensed Prescriber Order**

Montour School District

Student Name: _____ **Date/Time:** _____
School: _____ **Teacher/Grade:** _____

In accordance with school policy, medication(s) should be given at home before and/or after school. However, when this is not possible, prior to receiving the medication at school, each student must provide the school nurse with a *Medication Administration Consent* form signed by the student's parent/guardian and a *Medication Order* from a licensed prescriber. All medications must be in an original prescription bottle/container from a pharmacy. All medications must be brought in to school by a parent/guardian.

Parent/Guardian Consent:

I give my permission for my child, _____, to receive the following medication by a licensed prescriber during the school day. I understand that the medications will be given by school health personnel according to my child's licensed prescriber's directions. I hereby release the MSD and the health personnel from any liability whatsoever as a result of granting my request.

Parent/Guardian signature: _____ **Date:** _____
Parent/Guardian name printed: _____ **Phone:** _____

Licensed Prescriber Medication Order:

Patient's name: _____ **Date:** _____
Diagnosis: _____
Name of medication: _____
Route and dosage: _____
Time of administration: _____
Directions: _____
Discontinuation date: _____
Allergies: _____
Licensed prescriber signature: _____
Licensed prescriber name printed: _____ **Phone:** _____