

A. W. BEATTIE CAREER CENTER

9600 Babcock Blvd.
Allison Park, PA 15101

MEDICATION PROCEDURE FORM

It is required by A. W. Beattie Career Center that the attending physician fills out the following form for all medications to be given during school hours.

(Student's Name)

Date: _____
Grade: _____
Program: _____

(Medication and Dosage)

(Time Given)

(Date: _____ to _____ Date)

(Condition for which medication is requested)

(Possible side effects)

(Physician's Signature)

(Phone Number)

(Please Print Physician's Name)

(Address)

PHYSICIAN: Please check blocks that apply for inhalers, Epi-pens and other life saving medications:

- Student may carry and self-administer medication while on a field trip.
- Student may carry and self-administer medication on a daily basis.

PARENTAL PERMISSION, HOLD HARMLESS AND INDEMNIFICATION

We hereby agree that the medication be administered to our child as stated herein and agree with the intent to be legally bound hereby, to hold the A.W. Beattie Career Center and any of it's employees or agents harmless from any liability and to so indemnify same for any liability incurred which may result from administration or supervision of the medication to _____
by employees or agents of the A.W. Beattie Career Center.

(Parent or Guardian)

(Date)

A. W. Beattie Career Center Medication Policy requires a parent or guardian to bring the medication to school in the original container or prescription bottle. Return this form to the school office. No medications are permitted to be transported on the School Bus. A second labeled prescription bottle can be obtained from your pharmacist.

A. W. BEATTIE CAREER CENTER

SELF-ADMINISTRATION ABILITY VERIFICATION ASSESSMENT

Student's Name

Program & Grade

Date

To self-medicate, the student must be able to: (check all that apply)

- _____ 1. Respond to and visually recognize his/her name.
- _____ 2. Identify his/her medication.
- _____ 3. Demonstrate the proper technique for self-administering his/her medication.
- _____ 4. Sign his/her medication sheet to acknowledge having taken the medication.
Secondary students must maintain their own medication log, which may be reviewed by the school nurse at any time at her discretion.
- _____ 5. Demonstrate cooperative attitude in all aspects of self-administration of medication.
- _____ 6. Demonstrate knowledge of prescribed time intervals for inhaler use.

Name of Medication

Dosage

Frequency

The above named student has demonstrated the ability to self-administer the physician-prescribed asthma medication, as indicated by the criteria listed above.

Date

Signature (Health Science Teacher, R.N.)

As the parent/guardian of above named student, I relieve the A.W.Beattie Career Center and its employees of any responsibility for the benefits or consequences of the above listed medication when it is physician-prescribed and parent/guardian authorized. I further acknowledge that the school bears no responsibility for ensuring that the medication is taken. I am aware that any improper use/sharing of the above-mentioned medication will result in the immediate confiscation of the inhaler and loss of privilege to self-administer if the medication policy is violated.

Date

Parent/Guardian Signature

I agree to be solely responsible for my asthma inhaler and to follow the directions for its use as ordered by my physician, as well as A.W. Beattie Career Center's medication policy. I am aware that any improper use/sharing of the above-named medication will result in the immediate confiscation of the inhaler and loss of privilege to self-administer if the medication policy is violated. I am aware that I am responsible for maintaining a log of my inhaler use and must have it available for review by the school nurse at her discretion.

Date

Student Signature

Student is not able to self-administer at this time due to the following reasons: _____

Signature (Health Science Teacher R.N.)