EXHIBIT A

**MEDICATION STATEMENT FOR STUDENTS**

**WYOMISSING AREA SCHOOL DISTRICT**

**This form must be completed if a student needs to take medication at school.**

In accordance with recommendations of the Pennsylvania Department of Health and the school's Medication Policy, students will be given prescription medication or medications not routinely stocked in the nurse's office, only on the direct written order of a physician.

The medication must be in the original bottle which includes the prescription number and date.

**ALL MEDICATIONS AND SUPPLIES MUST BE STORED IN THE NURSE'S OFFICE. IT IS A VIOLATION OF SCHOOL POLICY FOR A STUDENT TO CARRY MEDICATIONS ON HIMSELF OR HERSELF. NO SELF-ADMINISTRATION OF MEDICATION IS PERMITTED EXCEPT FOR ASTHMA INHALERS AND EPIPENS.**

**ASTHMA INHALERS AND EPIPENS MAY BE CARRIED BY A STUDENT IF THE PROPER GUIDELINES ARE FOLLOWED ACCORDING TO THE SCHOOL'S POLICY AND THE PROPER PAPERWORK IS ON FILE IN THE NURSE'S OFFICE.**

The parent/guardian should bring the medication and the properly completed attached form to the nurse's office. The medicine will be given to the student by the school nurse, unless permission has been granted to self-administer an asthma inhaler or EpiPen. At the end of the designated time period, which shall be set by the physician, all unused medication will be returned to the parent/guardian or will be destroyed after notifying the parent/guardian if the medication is not picked up at the school.

The attached form must be completed by the parent/guardian and the physician before any medication will be administered. **A new form is needed each school year and for each new medication order.** The form, available from the nurse's office, must contain the following information: Name of Student; Diagnosis or reason for needing the medication; Name of medication; Dosage and time medication is to be given; Signature of parent/guardian; and Signature of physician.

If the above information is not completed, the nurse will refuse to honor the request to dispense the medication to the student. **Carrying medication without complying with the above information can result in disciplinary action.**

It is anticipated that administering medication during school hours will be the exception when necessary, rather than the rule. The Medication Policy is available at this school for your review.

**PLEASE COMPLETE THE ATTACHED FORM AND RETURN IT TO THE NURSE'S OFFICE.**

**MEDICATION WILL NOT BE ADMINISTERED WITHOUT THE COMPLETED, ATTACHED FORM.**

**WYOMISSING AREA SCHOOL DISTRICT**

**PERMISSION FOR SCHOOL NURSE TO GIVE PRESCRIPTION MEDICATION AT SCHOOL OR STUDENT SELF-ADMINISTRATION OF ASTHMA INHALER OR EPIPEN ONLY**

To be completed each school year and/or when student's medication changes.

PARENT/GUARDIAN IS RESPONSIBLE FOR INFORMING THE SCHOOL NURSE OF ANY CHANGES IN MEDICATION, DOSAGE, OR IF THE MEDICATION IS DISCONTINUED.

STUDENT'S NAME _____ GRADE_____
HOME ADDRESS _____ PHONE_____

**PHYSICIAN'S PERMISSION (or attach Physician's Statement)**

The student named above is being treated by me for (diagnosis)_____
and must/may take (medication) _____ Dosage_____

Time ____ noon/lunch
____ as needed
____ every 4 hours
____ not more than once per day
____ other (specify time) _____

For ____ days
____ remainder of the current school year
____ must carry on person
____ other (specify)_____

Potential serious reactions or side effects: _____
Emergency response if dose is ineffective:_____

The student is able to self-administer his/her inhaler or EpiPen (if applicable): yes/no (please circle one)

*I certify that I am the health care provider who prescribed the medication and that the student named above is my patient for diagnosis and treatment. I understand that the Wyomissing Area School District will be relying upon the directions I have set forth above.*

Physician Name _____ Physician Phone Number _____
Signature _____ Date _____

**PARENT'S/GUARDIAN'S PERMISSION**

*My child must/may take the medication specified above. I therefore request the school district nurse to give my child the above medication. I do hereby release, discharge and hold harmless, the school district, its agents and employees, from any and all liability and claim whatsoever for the administration of the above medication to my child or the benefits or consequences of the prescribed medication. In addition, the school district bears no responsibility for ensuring that the medication is taken. I acknowledge that I have read and understand the information page attached to this document concerning the use of medication in the Wyomissing Area School District.*

Signature _____ Date _____

**ASTHMA INHALER/EPIPEN USAGE**
**(only to be signed if student is to self-carry/self-administer asthma inhaler or EpiPen)**

*I hereby acknowledge that my child has permission to carry his/her asthma inhaler to use in case of an emergency. I acknowledge that the school is not responsible for ensuring the medication is taken. I also relieve the school and its employees of responsibility for the benefits or consequences of the prescribed medication.*

Signature _____ Date _____