POTTSGROVE SCHOOL DISTRICT

HEALTH SERVICES DEPARTMENT

PHYSICIAN REQUEST FOR MEDICATION ADMINISTRATION FOR ALLERGIC REACTION

NAME OF CHILD: _____
BIRTH DATE _____ GRADE_____

ALLERGIC TO:_____

REQUIRED TREATMENT:

Benadryl: Dosage-_____ Route-_____
When is medication to be given?_____
Follow up care:_____

EPI-PEN: Dosage-_____ Route-_____
When is medication to be given?_____
Follow up care:_____
EPI-PEN is to be kept: (check one) Nurse's Office_____ With child_____

*Student may carry & self administer EPI-PEN: Yes_____ No_____
*Child has been instructed in self-administration: Yes_____ No_____

*****ONLY for Middle & High School Students regarding Field Trips:***
*Student may carry & self administer Benadryl: Yes_____ No_____

_____ _____
Physician Signature Physician Name (Printed)

_____ _____
Date Phone Number

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PARENT REQUEST FOR MEDICATION ADMINISTRATION FOR ALLERGIC REACTIONS

I, the parent of _____request that the employees (nurse, principal, or designee) of the Pottsgrove School District administer or allow self-administration of the above named medication as prescribed by my child's physician in the event he/she has an allergic reaction at school. My signature on this document constitutes a complete waiver of liability claim in any and all respects against the Pottsgrove Area School District, and its Board of Directors and all its employees unless the District is negligent with regard to any claim for injury in connection with dispensation of the prescribed medication.

_____ _____
Date Signature of Parent/Guardian

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