



# Upper Merion Area School District

435 Crossfield Road • King of Prussia, PA 19406 • 610-205-6401 • Fax 610-205-6433 • www.umasd.org

## SCHOOL HEALTH SERVICES

Dear Parent/Guardian:

When it becomes necessary to administer any medication during school hours, these regulations apply:

1. A **signed physician's note** must be given to the School Nurse or Health Room Assistant for any **prescription or over-the-counter** medication to be taken during school hours. All notes must be renewed at the beginning of each school year and expire at the end of the school year.
2. A **signed parental/guardian permission note** for the medication must be given to the School Nurse or Health Room Assistant.
3. The medication must be provided in the **original pharmacy container** with the original label intact.
4. A parent, guardian, or another responsible adult must deliver the medication to the health suite.

If your child is to be given daily medication at school, please have these forms available on the first day the medication is to be administered. **NO MEDICATION WILL BE ACCEPTED FOR ADMINISTRATION UNTIL ALL FOUR OF THE REQUIREMENTS ARE MET.** Please keep the School Nurse or Health Room Assistant informed of any changes in the prescribed medication.

For your convenience, you may request a duplicate prescription container for the portion of the medication to be taken at home.

Thank you for your cooperation with the medication policy designed for the safety of all students.

### UPPER MERION AREA SCHOOL DISTRICT SCHOOL HEALTH SERVICES

#### Physician's Certificate for Medication taken During School Hours

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

Name of Medication \_\_\_\_\_ Strength \_\_\_\_\_

TYLENOL 325 mg and  
IBUPROFEN 200 mg.  
are kept stocked in  
school.

Directions for Dispensing \_\_\_\_\_

Possible Side Effects \_\_\_\_\_

Effective Dates: From \_\_\_\_\_ To \_\_\_\_\_

#### ALL MEDICATION ORDERS EXPIRE THE LAST DAY OF CURRENT SCHOOL YEAR

Physician's Signature \_\_\_\_\_ Phone \_\_\_\_\_

Printed Name of Physician \_\_\_\_\_

Parent's Signature \_\_\_\_\_

**Caley** 610-205-3655  
**Candlebrook** 610-205-3705

Form #5025 Rev. 5/06