Upper Bucks County Technical School

Serving: Palisades, Pennridge, and Quakertown

3115 Ridge Road • Perkasie, Pennsylvania 18944 • Phone: (215) 795-2911 • FAX: (215) 795-0273 • www.ubtech.org

Medication During School Hours

It is the procedure of this school to administer medications during school hours **ONLY WHEN ABSOLUTELY NECESSARY**

Please make every effort to plan a medication schedule so that all medications, whenever possible, are taken at home, rather than at school. Please discourage your child from using non-prescribed "over-the-counter" medications during school hours. UBCTS realizes, however, that at times your child may need to take a medication during school hours.
To protect your child and the other students, this permission/information sheet must be completed and returned to the school A.S.A.P. This form is for ***both prescription and non-prescription*** medication brought in from home.

Prescription and non-prescription medications sent to school must always be in the original container, registered and kept in possession of the school nurse/office, unless the physician or dentist indicates otherwise, i.e., inhalers, Epi-pen, etc.
All prescription meds must be sent in a container with the prescription labeled by the Pharmacist or Doctor, including the name of the drug, strength and dose of the drug, name of the student and time to be administered. This form may also be used for Tylenol & Ibuprofen [from infirmary supply] when documented as ***absolutely necessary*** by a physician or dentist.
Please Print Clearly:

TO BE COMPLETED BY PHYSICIAN/ DENTIST

Student Name___________________________________ **Age**_____**Grade**_____**Tech Class** _______________

Name of Medication_________________________________**Diagnosis**___________________________

Dosage_____________________________ **Frequency**____

Special Considerations:____

Effective Dates: From:__________________________**to**______________________________________

It is my understanding that the employees of Upper Bucks County Technical School charged with the administration of this procedure/treatment during school hours rely on the directions contained in this document. I further certify that I am the prescribing physician, that the above named student is under my care and I confirm that it is absolutely necessary for this medication to be administered during school hours.

Signature of Physician/Dentist____

Printed Name of Physician____

Address____

Phone Number____**Date**__________________________

TO BE COMPLETED BY PARENT/ GUARDIAN

I hereby request that the treatment described above be administered to my child and release Upper Bucks County Technical School and its employees from liability for any damages my child may suffer as a result of this request.

____ ______________________________________

Signature of Parent/Guardian **Telephone: home/cell/work**

____ ___________________ _____________

Printed Name **Program** **Grade**

____

Student Name **Student Signature**

The Upper Bucks County Technical School is an equal opportunity educational institution.

Permission for Student to Carry Medication at School

Student Name________________________________ Diagnosis____

Allergy____

Medication Order____

{ Drug - dose- frequency}

I release UBCTS and its employees from liability for any damages my child may suffer as a result of self-administration of this medication.

Furthermore, I understand that this medication may not be shared with another student and that such an act is a violation of the UBCTS's drug and alcohol policy.

Permission to Carry Prescribed Medicine/Medical Devices:

☐ I request that my child be permitted to carry his/her inhaler/Epi-pen,____________________(circle one or fill in) prescribed for asthma/severe allergic reaction to____________________ (circle one and/or fill in), on his/her person in school, or to keep the inhaler in his/her locker(s).

My child has been instructed in its use and is considered by me to be responsible for its care and use. To have this request granted, I absolve/release the school of responsibility and liability for any misuse of this medication by my child.

____	____
Parent/Guardian Name (Please Print Clearly)	Parent/Guardian Signature
____	____
Daytime Phone Number	Date

The Upper Bucks County Area Vocational Technical School is an equal opportunity educational institution.