Dear Parent/Guardian,

We attempt to discourage administration of medications to students during the school day. However, if your physician decides it is necessary for your child to receive a medication during the school day, the physician’s approval and specific directions must be provided to the school. It is recommended the first doses of medications be administered at home. In the event that a physician specifically grants permission for your student to carry his/her inhaler at all times and self-medicate, or self-medicate any other medication for that matter, I hereby release RMCTC of any legal responsibility for the decision to administer or the responsibility of the actual administration of said medication.

Please send the medication to school in the original pharmacy bottle with the current prescription label on the container. Upon request, your pharmacist will give you a second labeled bottle/container to use either at home or to have the student’s medicine taken to school.

To insure your child receives the proper care, complete this form and return it immediately to the health room AND have a physician’s order – signed by the doctor – sent to the school as soon as possible.

Mrs. Mary Beth Feeg, RN
Reading Muhlenberg CTC
School Nurse
610-921-7300 ext 7429
Reading Muhlenberg CTC
School Nurse
2615 Warren Road
Reading, PA 19604

I hereby give my permission for the nurse or responsible school personnel to administer medication, according to the prescription’s directions, during the day to my child.

_____________________________________________                              _________________________________
Name of Child                                                                                                 Program Area

Name of Medication__________________________________________________________________________

Amount to be given/dosage_______________________________________________________________

Time to be given_____________________________________________________________________________

Doctor Prescribing Medication________________________________________________________________

Reason for taking Medication__________________________________________________________________

Is this child taking other medication?_____If so, what?________________________________________

Date_________________________Signature of parent or Guardian______________________________

Home Phone __________________________________________ Work Phone _______________________________