

Saint Agnes-Sacred Heart  
MIDDLE SCHOOL  
ADMINISTRATION OFFICE  
100 Broad Street/ PO Box 31  
Hilltown, PA 18927  
Telephone: 215-822-9174  
Fax: 215-822-7942



Saint Agnes-Sacred Heart  
PRIMARY SCHOOL

393 North Main Street  
Sellersville, PA, 18960  
Telephone: 215-257-3571  
Fax: 215-257-8036

## MEDICATION FORM

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

School \_\_\_\_\_ Fax # \_\_\_\_\_ Phone \_\_\_\_\_

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### Medication Treatment Plan to be completed by Physician

Diagnosis: \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Specific Time \_\_\_\_\_

Direction for Administration \_\_\_\_\_

**NOTE: Medication must be supplied in the original prescription container.** Ask the pharmacist to divide the medication into two completely labeled containers, providing one for home and one for school.

Side Effects/ Special Instructions: \_\_\_\_\_

**NOTE TO PHYSICIANS:** Please complete the treatment plan of the back of this form for students who require any special health procedures during school hours; i.e., inhalers, nebulizer treatments, catheterization, suctioning, tube feedings, glucose testing, etc.

Printed Name Physician \_\_\_\_\_ Address \_\_\_\_\_

Physician's Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

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### Parental Permission to be completed by Parent(s)/Guardian(s)

I grant the administrator or his/her designee the permission to assist in the administration of each prescribed medication/procedure to be provided during the school day, including when Student \_\_\_\_\_ is away from school property on official school business.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Home Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_