



**Elbow Lane School**  
 828 Elbow Lane, Warrington, PA 18976  
 School: 215-343-2124 Fax: 215-933-1469  
 Director: Lisa Puchalski mrsp@elbowlane.com  
 Asst. Director: Jenn Kunigus jennk@elbowlane.com

# MEDICATION DISPENSING FORM

**No medication will be administered to any child without the proper completion of this form.**

**This form should be used for prescription medication, non-prescription medication, and non-prescription topical ointments/creams. Any medication to be administered by school personnel must be delivered in the original and properly labeled container to the school or designated classroom teacher along with this form.**

Medication will be administered to children during school hours only when such medication is needed by the children to remain in school and administration is required during school hours. Medicine should be in its original, child resistant, properly labeled container. Prescription medication must also have the proper labeling by a pharmacist complete with name of the licensed health professional who ordered the medication.

Failure of the parent or guardian to provide documentation will require the parent or guardian to be present in school to administer the medication personally. Form is to be updated every 6 months.

**Child's name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Classroom:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Name of Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_  
 Treatment or procedure: \_\_\_\_\_  
 Reason for Medication: \_\_\_\_\_  
 Effective dates: From: \_\_\_\_\_ To: \_\_\_\_\_ Refrigeration Requirement: YES  NO

Name of Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_  
 Treatment or procedure: \_\_\_\_\_  
 Reason for Medication: \_\_\_\_\_  
 Effective dates: From: \_\_\_\_\_ To: \_\_\_\_\_ Refrigeration Requirement: YES  NO

Name of Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_  
 Treatment or procedure: \_\_\_\_\_  
 Reason for Medication: \_\_\_\_\_  
 Effective dates: From: \_\_\_\_\_ To: \_\_\_\_\_ Refrigeration Requirement: YES  NO

**Non-prescription topical ointment/creams (check off for permission)**

- |   |  |
|---|--|
| <input type="checkbox"/> Diaper Cream _____     | <input type="checkbox"/> Lip Balm/ointment _____ |
| <input type="checkbox"/> Hand/body Lotion _____ | <input type="checkbox"/> Sunblock _____          |
| <input type="checkbox"/> Other _____            | <input type="checkbox"/> Other _____             |

It is my understanding that the employees of Elbow Lane School charged with the administration of this treatment/procedure during school hours may rely on directions contained in this document. I further certify that I am the physician/dentist who prescribed the treatment/procedure and that the student named above is under my supervision as a patient.

**Signature of Physician/Dentist** \_\_\_\_\_ **Phone #** \_\_\_\_\_  
**Address** \_\_\_\_\_ **Fax #** \_\_\_\_\_ **Date:** \_\_\_\_\_

As parent/guardian of the above child, I hereby request that the treatment/procedure described above be administered to my child and release Elbow Lane School and its employees from liability for any damages my child may suffer as a result of this request.

**Signature of Parent/Guardian** \_\_\_\_\_ **Phone #** \_\_\_\_\_