



MIDDLE BUCKS
INSTITUTE OF TECHNOLOGY

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MEDICATION DISPENSING FORM

All medication, both prescription and non-prescription, must be kept in the Health Office. Medication will be administered to students during school hours when such medication is required and accompanied by a doctor's order.

No medication, except those designated on the Student Emergency Form, shall be administered to any student without proper completion of the Middle Bucks Institute of Technology Medication Dispensing Form. The term "medication" includes prescription drugs as well as over the counter medications. Completion of the form includes signatures of both parent/guardian and physician. A separate form must be used for each medication and be specific as to the dosage.

Any medication to be administered by school personnel must be delivered directly to the school nurse, the school director, or his/her designee. Medication must be brought to school in the original, properly labeled container.

In cases when the Medication Dispensing Form is not available and the administration of medication is necessary, nurses may obtain verbal orders from the attending physician. However, any order for this medication to be given at school any time following must be accompanied by a signed Medication Dispensing Form.

TO BE COMPLETED BY THE PHYSICIAN/DENTIST

Student's Name: _____ Age: _____ Grade: _____ School: _____

Name of Medication: _____ Dosage: _____ Time: _____

Special Considerations: _____

Reason for Medication: _____ Effective Date From: _____ To: _____

*****Epi-Pen or Inhaler Only – Student may self-carry /self-administer _____**

It is my understanding that employees of the Middle Bucks Institute of Technology charged with the administration of this treatment/procedure during school hours rely on directions contained in this document. I further certify that I am the physical/dentist who prescribed the treatment and that the above student is under my supervision as a patient.

Signature of Physician/Dentist: _____ Printed Name: _____

Address: _____

Phone number: _____ Fax: _____ Date: _____

TO BE COMPLETED BY PARENT/GUARDIAN

As parent/guardian of the above named student, I hereby request that the treatment described above be administered to my child and release Middle Bucks Institute of Technology and its employees from liability for any damages my child may suffer as a result of the request.

Signature of Parent/Guardian: _____ Date: _____

Home Phone: _____ Cell: _____ Work: _____

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