Medication Administration Consent Order Form

Student Name _____ Date_____

School _____ Grade_____

The Freedom Area School District policy for administration of medication is as follows:

Prescription Medication: I understand that prescription medication must be in the container in which it was purchased; and the name of the medication, the dosage and the times to be given, the licensed prescriber/physician's name must be printed on the container, along with an order from the licensed prescriber/physician and consent of the parent/guardian.

Over-the Counter Medication- I understand that over-the- counter medication (such NSAIDS, antacids, cough medication) must be provided by the parent, in the original container, along with an order from the licensed prescriber/physician and consent of the parent/guardian.

All medication should be taken by the parent/guardian directly to the certified school nurse to be stored throughout the day. Please contact your school's certified nurse if you require any special consideration. No medication will be administrated without the completion of this form and the signatures of the parent /guardian and licensed prescriber/physician.

I give permission for the licensed certified school nurse/licensed health personnel to contact the licensed prescriber/physician or pharmacist regarding this medication.

Any medication not picked up by the end of the school year will be disposed by school nurse via waste disposal guidelines/regulations as governed by the State of Pennsylvania.

Parent/Guardian Consent

I give my permission for my child, _____, to receive the following medication ordered by a licensed prescriber/physician during the school day. I understand that the medications will be given by licensed certified school nurse/licensed health personnel according to my child's licensed prescriber/physician's order.

Parent /Guardian Signature _____Date_____

Parent /Guardian Name (Printed) _____Phone# _____

Licensed Prescriber/Physician Medication Order

In accordance with school policy, medication(s) should be given at home before and/or after school. However, when this is not possible, prior to receiving the medication at school, each student must provide the certified school nurse with a Medication Administration Consent Order form annually signed by the student's parent/guardian and a licensed prescriber/physician.

Patient/Student Name _____Date_____

Name of medication: _____

Dosage: _____ Route: Oral_____ Injection _____ Inhalation_____ Other____

Time of administration: _____

Reason for Medication: _____

Discontinuation date: _____

Allergies: _____

Side Effects or contraindications: _____

The above student has demonstrated the ability to self-carry and/or self-administer the prescribed Asthma inhaler and/or Epinephrine Auto-Injector medication.

Yes_____ No_____

Licensed Prescriber Name (Printed)_____

Licensed Prescriber Signature _____ Date_____

Phone# _____