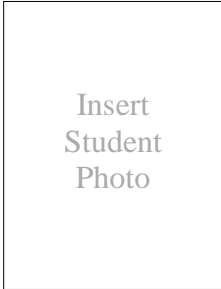


Parkland School District  
School Health Services

**Medication Administration Consent and Licensed Prescriber Order**



Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_ Teacher/Grade: \_\_\_\_\_

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 school nurse with a *Medication Administration Consent* form signed by the student's parent/guardian and *Medication Order* from a licensed prescriber. All medications must be in an original prescription bottle/container from a pharmacy. **Prescribed Medications ordered below will only be administered between the hours of 7:30 am-2:45 pm secondary & 8:50 am-3:30 pm elementary. Emergency procedures will be followed during bus rides to and from school.**

**Parent/Guardian Consent:**

I give my permission for my child, \_\_\_\_\_, to receive the following medication ordered by a licensed prescriber during the school day. I understand that the medications will be given by school health personnel according to my child's licensed prescriber's directions. **I do hereby release, discharge, and hold harmless the Parkland School District, its agents and its employees from any and all liability whatsoever for the administration of the prescribed medication to the child named above and pursuant to these directions.**

Parent/Guardian Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_

Parent Phone # \_\_\_\_\_ Date: \_\_\_\_\_

2020-2021

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**Licensed Prescriber Medication Order:**

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

Name of medication: \_\_\_\_\_

Dosage and Route: \_\_\_\_\_

Time schedule for administration: \_\_\_\_\_

Time interval for second dose of Epinephrine Auto-Injector if applicable: \_\_\_\_\_

Other medication prescribed by physician that student is taking outside of school hours: \_\_\_\_\_

Is student capable of self-administration? Yes \_\_\_\_\_ No \_\_\_\_\_

The student has been trained in self-administration of asthma inhaler &/or Epinephrine Auto-injector  
Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

Student may carry asthma inhaler/ Epinephrine Auto-injector in school: YES \_\_\_\_ NO \_\_\_\_

Licensed Prescriber signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Licensed Prescriber phone #: \_\_\_\_\_ Date: \_\_\_\_\_