Parkland School District
School Health Services

Medication Administration Consent and Licensed Prescriber Order

Insert Student Photo

2020-2021

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: _____

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: _____