Reading School District
Student Services ~ Health Services Department

Medication Administration Consent and Licensed Prescriber Order

Dear Parent / Guardian:
We attempt to discourage administration of medication in the schools. However, if your physician decides it is necessary for your child to receive medication during the school day, the following instructions must be followed:

- The prescribing physician must complete the lower half of this form.
- The first two doses of the medication must be given at home.
- The medication must be brought to school by the parent / guardian or responsible adult (exceptions must be discussed with the Certified School Nurse).
- The medication must be in the original pharmacy container with the current and correct prescription label on the container.

I give permission for my child to receive the following medication according to the directions of the licensed prescriber. I understand that the medication will be given only by school health personnel accordance with school policy.

Child's Name:_____ Grade:_____Homeroom_____

Parent Signature:_____ Date:_____
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SELF-MEDICATION ADMINISTRATION:

I give permission for my child:_____**to self-administer his / her medication. I understand that self-administration will only occur with the written approval of the licensed prescriber and upon completion of the self-medication assessment completed by the certified school nurse.**

Parent Signature:_____ Date:_____

TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Student:_____ DOB:_____
Diagnosis:_____
Name of Medication:_____ Dose:_____
Time of Administration (specify hour)_____ Route:_____
Discontinuation Date:_____
Allergies:_____
Check BP & pulse _____ QD x _____ days; Check weight _____ week x _____days
Please observe and report to the prescribing health care provider the following possible side effects:

_____
Restrictions while medication is being taken:_____
Other medications taken at home: Name / time given_____
Name / time given_____
Name / time given_____
Student may self-administer this medication: YES_____ NO_____
Health Care Provider Signature:_____**Date:**_____
Health Care Provider Printed Name_____
Phone:_____ Fax:_____
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Signature of Certified School Nurse:_____
School:_____
Phone:_____ Fax:_____

Self-medication assessment completed by CSN; Student may self-administer med. Yes_____No_____