DOWNINGTOWN AREA SCHOOL DISTRICT

AUTHORIZATION FOR MEDICATION ADMINISTRATION (210-AG)

Physician authorization and parent consent is required for the administration
of prescription and over the counter medications in school.
New medication orders are required annually and must be dated after June 30th.
All medication MUST be delivered to the nurse's office by parent/guardian
in a secure original pharmacy-labeled container.

Student's Full Name:_____ **Grade/Homeroom**_____
Date of Birth:_____**Allergies:**_____
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Name of medication (Prescription/OTC):_____

Diagnosis/condition for which medication is prescribed:_____

Route of administration:_____

Dosage:_____**Time of administration:**_____

Date medication administration begins:_____**Date medication administration ends**:_____

In the event of a 2-hour delayed school opening, medication will be administered as indicated:
____**@ original time noted above** ____**@home only** ____**@ the following time**:_____

_____Student is able to **self-carry** the emergency medications noted above--which are limited by law to include diabetes management medications/supplies, glucagon, asthma rescue medication, epinephrine auto injector--to/from/during school, on field trips, and at extra-curricular activities.
_____Student is competent to **self-administer** the emergency medications noted above--which are limited by law to include diabetes management medication/testing supplies, asthma rescue inhaler, epinephrine auto injector--to/from/during school, on field trips, and at extra-curricular activities.
_____Student is not permitted to self-carry and/or self administer any emergency medications.

_____/_____ _____
Physician's Signature **Date** **Physician's Printed Name**

By signing below, parent requests the administration of the above-named medication as prescribed by the authorizing physician AND acknowledges their consent to permit their student to self-carry and/or self-administer diabetic management medications/supplies and/or emergency medications as determined by the physician's authorization stated above.

****Student's school-based competency to self-administer all referenced medications/supplies will be determined by the school nurse** (No. 210.1-AG).**

_____/_____ _____
Parent/Guardian Signature **Date** **Parent/Guardian Printed Name**