Medication Administration Consent and Doctor's Prescribed Orders

Student Name: _____Date of Birth_____

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 Authorization Consent* form signed by the student's parent/guardian and a *Medication Order* from a licensed prescriber. All medications must be in an original bottle/container from a pharmacy.

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 the school health personnel according to my child' licensed prescriber's directions and that some or all of this information may be shared with individual school staff on a need to know basis, as determined by the Certified School Nurse. The Nurse will use this information to develop an Emergency Care Plan in order to provide optimal care for your child.
If my child's doctor and I give permission for him/her to carry and self-administer his/her own Asthma Inhaler and/or Epi-pen Auto injector and he/she has demonstrated competency to the School Nurse I am also relieving the school entity or any school employee of any responsibility for the benefits or consequences of the prescribed medication and acknowledge that the school entity bears no responsibility for ensuring that the medication is taken.

Parent/Guardian signature: _____**Date:** _____

Parent/Guardian name printed: _____ **Phone**: _____

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DOCTOR MUST COMPLETE THIS PORTION

Patient's name: _____**Date of Birth** _____

Diagnosis: _____**Date**_____

Name of medication: _____ **Directions:** _____

Additional Information: (i.e. Allergies or possible side effects, if applicable): _____

_____

Known Allergies: _____

Is student capable of Self Administration (only Asthma, Epi-Pen) ***Check One*** **Yes**_____ **No**_____

Licensed Prescriber signature: _____ **Phone:** _____

Licensed Prescriber name printed: _____**Fax:** _____

Medication Received? ____ **By:** _____ **Amt:** _____ **Date:** _____