Lampeter Strasburg School District
1600 Book Road - P.O. Box 428 Lancaster, PA, 17602
Phone: 717-464-3311 Fax: 717-358-1075

Medication Administration Consent Form

Name of Student_____**Date of Birth**_____

School Attending_____**School Year**_____**Grade**_____

PA Dept. of Education Regulations for Medication Administration in School: Medication should be ordered to be given to a student at school ONLY WHEN ABSOLUTELY NECESSARY. All medication administered in school must be prescribed by a licensed physician or other authorized prescriber. Medication must be provided in the original pharmacy-labeled container, with the child's name, medication name, dosage, and administration instructions clearly indicated. Students capable of self-administration must have a written authorization from a physician/care provider and parent/guardian. Medication administration on field trips must adhere to the same regulations as medication administration in school.

Parent/Guardian Permission Statement:
I, _____, give permission for the above-named medication to be administered to my child as directed. I understand that it is my responsibility to provide the medication to the school and to inform the school of any changes in the medication or dosage, along with a doctor's order reflecting this change. I release school personnel from liability in the event of adverse reactions resulting from taking the medication. I give permission for emergency medical treatment in case of necessity. I give permission for the school nurse to communicate with the prescribing physician/caregiver regarding this medication. I give permission for the medication(s) to be given by designated personnel as delegated by the school nurse.

Parent/Guardian Signature_____**Date**_____

TO BE COMPLETED BY HEALTHCARE PROVIDER:

Start Date:	**Stop Date:**	**Today's Date:**

Medical Condition	Medication	Dosage	Frequency	Route	Side Effects

( ) Does not need medication administered on field trips

Provider/Physician Name (print) **Provider/Physician Signature**

Provider/Physician Practice **Phone Number** **Fax Number**

Self-Administration of Rescue Asthma inhalers/Epinephrine Auto Injectors Section:
I, the undersigned physician, confirm that the student named above is capable of self administering the medication described herein.

Physician's Signature_____ **Date:**_____

Parent/Guardian Signature:_____ **Date:**_____

Student's self-administration reviewed/approved by: _____ **Date:**_____
(School Nurse)

Note: This form must be completed by the physician/primary care provider, parent/guardian and reviewed by the school nurse and/or other relevant school officials.