

**Medication Administration Consent And
Licensed Prescriber Order**

Bangor Area School District

Student Name: _____ Date of Birth (DOB): _____

School: _____ Teacher/Grade: _____ Date/Time: _____

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 a *Medication Order* from a licensed prescriber. All medications must be in an original prescription bottle/container from a pharmacy. Parent(s) or guardian(s) of students must bring the medication to school for their child. Students are not permitted to bring medication(s) to school. Any change in medication must be reported to the school nurse immediately.

Parent/Guardian Consent:

I give my permission for my child, _____, to receive the following medication 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.

Parent/Guardian signature: _____ Date: _____

Parent/Guardian name printed: _____ Phone: _____

Licensed Prescriber Medication Order:

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

Name of medication: _____

Route and dosage: _____

Time of administration: _____

Directions: _____

Discontinuation date: _____

Allergies: _____

Licensed prescriber signature: _____

Licensed prescriber name printed: _____ **Phone:** _____