

# MEDICATION ADMINISTRATION CONSENT & LICENSED PRESCRIBED ORDER

## Carbondale Area School District

Student Name: \_\_\_\_\_ Date/Time: \_\_\_\_\_

School: \_\_\_\_\_ 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 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/Guardian Consent:

I give my permission for my child, \_\_\_\_\_, to receive the following medication order 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.

\_\_\_\_\_ *My child is capable of self-administering the medication listed below and has been instructed in the use of, and has permission to carry and take, this medication on his or her own as directed further down.*

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian name printed: \_\_\_\_\_ Phone: \_\_\_\_\_

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### Licensed Prescriber Medication Order:

Patient's name: \_\_\_\_\_ Date: \_\_\_\_\_

Name of medication: \_\_\_\_\_

Route and dosage: \_\_\_\_\_

Time of administration: \_\_\_\_\_

Directions: \_\_\_\_\_

*The student has been instructed in the use of an inhaler/Epi-Pen and has permission to carry and take this medication on his or her own as directed above. YES \_\_\_\_\_ NO \_\_\_\_\_*

Discontinuation date: \_\_\_\_\_

Allergies: \_\_\_\_\_

Licensed Prescriber signature: \_\_\_\_\_

Licensed Prescriber name printed: \_\_\_\_\_

Licensed Prescriber phone number: \_\_\_\_\_