School Medication Administration Consent and Licensed Prescriber Order

This form must be completed fully in order for schools to administer the required medication. A new medication administration form must be completed at the beginning of each school year (after July 1st), for each medication, and each time there is a change in dosage or time of administration of a medication.

- ❖ Prescription medication must be in a container labeled by the pharmacist or prescriber.
- ❖ Over-the-Counter (OTC) medication must be in the original container with the label intact.

Licensed prescriber's medication order for prescription medication (or) parental request for over-the-counter medication:

School year: _____

Student Name: _____ **DOB:** _____ **Grade**_____

Condition for which the medication is being administered: _____

Medication: _____ **Dose:** _____ **Route:** _____

Time/Frequency of administration: _____ **If PRN, frequency:** _____

Specific instructions of administration: _____

Possible side effects or contraindications: _____

If this medication is an inhaler or EpiPen, is the student capable of independently carrying and administering this medication? ___Yes ____ No

Prescribers' Name/Title_____

Telephone: _____ FAX:_____

Address: _____

Licensed Prescriber's Signature: _____ **Date:** _____

School Physician's Signature for Over-the-Counter Medication Request: _____ **Date:** _____

PARENT/GUARDIAN AUTHORIZATION

I request designated school personnel to administer the medication as prescribed by the above prescriber or as I requested with the school physician approval/signature. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I understand that **a designated adult or I must bring the medication to school and/or pick-up the medication**. At the end of the school year, a designated adult or I must pick up the medication, otherwise it will be discarded. I authorize the school nurse to communicate with the health care provider as allowed by HIPAA. I hereby release Shippensburg Area School District and all its employees from any liability for damages my child may suffer as a result of this request. I have read and agree to comply with the " Use of Medication" policy #210 and "Possession/Use of Inhalers/Epinephrine Auto-Injectors" policy #210.1 if applicable.

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

Adopted: July 17, 2023