

# Medication Administration Consent And Licensed Prescriber Order Deer Lakes

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. Following guidelines must apply:

1. For the safety of your child, students are NOT permitted to transport or carry any medication (over the counter or prescription) at any time. Exceptions are outlined below.
2. No medications will be given back to the student to transport home.
3. Prescription medications must be in the original prescription labeled container (you can request a duplicate container from the pharmacist) accompanied by this form or a physician written order and a detailed note with parent/guardian signature.
4. Non-prescription medication must be in the original container with the student’s name and accompanied by this form or a detailed note, indicating name of medication, dose and time to give from parent/guardian. The nurse will request a physician’s order to administer over the counter medications.
5. Students who are authorized by a doctor to carry/or self administer a medication violate thee Alcohol and Other Drug Policy IF he/she permits another student to take or ingest the medication.
6. Any medication not picked up by the end of the last day of school will be disposed of in a non-recoverable manner.

**Parent/Guardian Consent:**

I have read the above information and 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: \_\_\_\_\_

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**PRESCRIPTION/OVER COUNTER MEDICATIONS**

**The PHYSICIAN must complete the following:**

**Licensed Prescriber Medication Order:**

Patient’s name: \_\_\_\_\_ Date: \_\_\_\_\_

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

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

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

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

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

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

List Significant side effects: \_\_\_\_\_

**PERMISSION TO CARRY AND/OR SELF MEDICATE**

Is the child authorized to self medicate herself/himself? YES NO

Student may carry inhaler, epipen (or other) in school or on Field Trips? YES NO

Licensed prescriber signature: \_\_\_\_\_

Licensed prescriber name printed: \_\_\_\_\_ Phone: \_\_\_\_\_