School District of Springfield Township
Medication Administration Consent & Licensed Prescriber Order

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.

Licensed Prescriber Medication Order:

Patient's name:____ **Date:** ___________________

Diagnosis:____

Name of medication: ____

Route and dosage: ____

Time/frequency of administration: ____

Directions: ____

Possible side effects:____

Discontinuation date:____

Allergies: ____

Licensed Prescriber signature/title: ____

Licensed Prescriber name printed:____ **Phone:** _____________

Parent/Guardian Consent:

I give my permission for my child, ____________________________________, to receive the above medication ordered 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:_________________

Self Carry/Self Administration of Emergency Medication Authorization/Approval

Prescriber's authorization for self-carry/self-administration of emergency medication:

Signature____ Date:________________________

Parent authorization for self-carry/self-administration of emergency medication:

Signature____ Date:_________________________

School RN approval for self-carry/self-administration of emergency medication:

Signature____ Date:________________________