Penn Cambria School District
Medication Administration Consent & Licensed Prescriber Order

Student Name: ______________________________ Date: ____________ DOB: ____________

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 and brought into school by a parent/guardian when possible. This order applies to all over-the-counter medications as well as prescriptions.**

Licensed Prescriber Medication Order:

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

Name of medication: ____

Diagnosis: ____

Route and dosage: ______________________________ **Time of administration:** ____________

Directions: ____

Side Effects: ____

Allergies: ____

Discontinuation Date: __________________

Licensed Prescriber signature: ____

Licensed Prescriber name printed: ____________________________**Phone:** _______________

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Parent/Guardian Consent:

I give my permission for my child, ________________________________, to receive the following 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: _____________

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