SOUDERTON AREA SCHOOL DISTRICT

School Health Services

Medication Administration Consent & Licensed Prescriber Order

Student Name: _____ **Teacher/Grade:** _____

In accordance with school policy, medication(s) should be given at home before school and/or after school. If it is essential that your child receives medication during the school day, please complete this form in full and return it to the nurse's office with medication upon arrival at school.

- The medication must be in the original container.
- Prescription medications must be in a pharmacist's labeled bottle.

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.

☐ **The school nurse may discuss medication concerns with the physician**.

Parent/Guardian signature: _____ Date: _____

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Licensed Prescriber Medication Order:

Patient's Name: _____ **Date:** _____

Name of medication: _____

Directions: _____

Discontinuation date: _____

Diagnosis/Reason to be taken: _____

Allergies : _____

Licensed Prescriber signature: _____**Date:** _____

Licensed Prescriber name printed: _____**Phone:** _____