Medication Administration Consent And Licensed Prescriber Order

Daniel Boone School District

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.

Parent/Guardian Consent:

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: _____________________

Licensed Prescriber Medication Order:

Patient's name: _____________________________________ **Date:** _____________________

Name of medication: ____

Route and dosage: ____

Time of administration: ____

Directions: ____

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Discontinuation date: ____

Allergies: ____

Licensed prescriber signature: ____

Licensed prescriber name printed: _____________________ **Phone:** __________________