Tunkhannock Area School District

Medication Administration Consent / Licensed Prescriber's Order

Student Name: _____ DOB_____ Date_____

School: _____ Grade/Teacher_____

When it is necessary for children to receive medication at school, parent/guardian must sign a Medication Consent, and a licensed prescriber must sign the Medication Order. All medications, prescription and over the counter medicines, must be delivered by a parent/ guardian or responsible adult in an **original pharmacy labeled container**. We may accept up to a thirty-day supply of medicine.

Medication Consent: To be completed by parent/guardian

I give permission for my child, _____, to receive the following medication ordered by a licensed prescriber during the school day.

Parent/Guardian signature: _____ Date: _____

Parent/Guardian name (printed) _____ Phone: _____

Medication Order: To be completed by prescribing physician

Name of medication: _____for treatment of _____ (diagnosis)

Dose_____, Route_____, Frequency _____, Time_____

Side effects: _____

Emergency Response: _____

The student is competent and able to self-administer medication as indicated by circling one or more of the following, **(epi pens, asthma inhalers and insulin only)** while practicing proper safety precautions.

Yes _____ No _____

The student is capable of safe self-monitoring of blood glucose while practicing proper safety precautions.

Yes _____ No_____

Medication administration may be withheld while student is on a school field trip:

Yes_____ NO _____

Discontinuation date: _____

Allergies: _____

Licensed Prescriber signature: _____ Date: _____

Licensed Prescriber name printed _____ Phone: _____