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:_____