

**Medication Administration Consent And  
Licensed Prescriber Order**

**Upper St. Clair 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:** \_\_\_\_\_  
\_\_\_\_\_

**Discontinuation date:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_

**Licensed prescriber signature:** \_\_\_\_\_

**Licensed prescriber name printed:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**06/29/2020**