MEDICATION ADMINSTRATION CONSENT AND LICENSED PRESCRIBER ORDER

CRAWFORD COUNTY CAREER & TECHNICAL CENTER

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 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 prescribed 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.

_____ I authorize my child to self-medicate this prescribed medication.
**Self-medication is only valid for asthma inhalers and epinephrine auto-injectors.
(By doing so, I acknowledge that the school is not responsible for ensuring that the medication is taken, and I release the school and its employees of responsibility for the benefits or consequences of the prescribed medication.)

_____ I authorize the exchange of information (both verbal and written) concerning my child at any time during the school year between the licensed prescriber and school nurse/health technician.

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: _____ Discontinuation Date: _____

Directions: _____

_____

Precautions: _____

Allergies: _____

Student may **SELF-MEDICATE*** this medication at school: **YES** or **NO**
*For use of Asthma Inhaler or Epinephrine Auto-injectors ONLY.
*I certify that this student is qualified and able to self-administer this medication.

Licensed Prescriber Signature: _____

Licensed Prescriber Name Printed: _____ Physician's Phone#: _____