JEFF TECH
576 Vo Tech Road
Reynoldsville, PA 15851
(814) 653-8265
FAX (814) 653-8425

Medication Administration Consent

Student Name: _____ Date: _____

Teacher/Shop: _____

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 permission for my child, _____, to receive the following 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: _____

Licensed Prescriber Medication Order:

Patient's Name: _____ Date: _____

Allergies: _____

Name of Medication: _____

Route and Dosage: _____

Time of Administration: _____

Possible Side Effects: _____

For Epi-pens and Inhalers ONLY – Does student need to self-carry/self-administer?

_____

Procedure to follow if reaction occurs: _____

Discontinuation Date: _____end of 2023 – 2024 school year_____

Licensed Prescriber signature: _____

Licensed Prescriber name printed: _____ Phone: _____

For Nurse's Office Use Only:
If student is to self-carry/self-administer, did they demonstrate the use and sign the contract? _____ (Initials/Date)