UPPER DARBY SCHOOL DISTRICT

Medication Administration Request and Consent Form

PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS

District policy states that in order to give prescription medications and over the counter (OTC) medications, the School Nurse needs the following for each medication:

- A signed order from your child's licensed care provider (physician, dentist, PA, or CRNP). The form below is provided for your convenience.
- A signature from parent/guardian.
- Medication must be provided in the original pharmacy prescription container or OTC container (medication in baggies, envelopes, or other family member's prescription bottle will not be accepted).

It is the responsibility of the parent to obtain proper documentation.

The above requirements must be renewed every school year.

Parent/Guardian must bring the medication into school – not the student. Parent/Guardian is responsible for providing a new prescription when medication has expired or has run out.

Parents are encouraged not to send in (OTC) medications for the Nurse to administer unless specifically prescribed by the child's licensed care provider.

Medications for field trips and extra-curricular activities will only be permitted when the above requirements are met and the medication is brought to the school nurse **at least 5 days prior to the trip or activity.**

District medication policy permits a responsible, trained student to carry and/or self-administer medication for asthma, severe allergic (anaphylactic) reaction, or diabetes on his/her person for immediate use in a life-threatening situation with written order of licensed provider, parent request, school nurse, and principal approvals. **Please have the licensed provider and parent fill out and sign the reverse side of this form for self-carry and self-administration.**

STUDENT NAME_____ **GR**_____ **RM**_____

DATE OF BIRTH _____ **ALLERGIES**_____

NAME OF PRESCRIBED MEDICATION_____ **DOSAGE**_____

ROUTE (oral, topical, etc) _____ **TIME(S)**_____ **DAILY**_____ **PRN**_____

DIAGNOSIS _____

SPECIAL INSTRUCTIONS _____

NAME OF LICENSED PROVIDER_____ **PHONE #**_____

SIGNATURE OF LICENSED PROVIDER_____ **DATE**_____

OFFICE STAMP:

PARENT SIGNATURE _____ **DATE** _____

Upper Darby School District
Consent to Self-carry and Self-administer

Special instructions for prescriber regarding orders for emergency medication such as epinephrine, "rescue" asthma inhalers, and medication for diabetes:

NAME OF STUDENT_____ **DOB**_____**GR**_____

Diagnosis for which medication is prescribed: _____

Name of medication, dose, and method administered: _____

Time or indication for administration: _____

Possible side effects/adverse reactions: _____

Start date: _____ **End date:** _____ **(Limit of one school year)**

Specific instructions regarding administration: _____

IN MY OPINION, THIS STUDENT SHOWS CAPABILITY TO CARRY AND SELF-ADMINISTER THE ABOVE MEDICATION.

Licensed Provider Signature	**Print Name**	**Phone #**	**Date**

PARENT/GUARDIAN AUTHORIZATION

I request that my child, named above, be permitted to carry and self-administer the above ordered medication. I take responsibility for this permission. I understand that the medication must be in the original pharmacy container, labeled with name of student, prescribing licensed provider and medication, date of original prescription, strength and dose of medication, and directions for use.

Parent Signature	Date	Student Signature	Date

The School Nurse will accept the parent request and physician statement. The School Nurse will permit and assist the student to be responsible, but reserve the right to withdraw the privilege if the student shows signs of irresponsible behavior or if there is a safety risk. The School Nurse will contact the parent as soon as possible in this event.

School Nurse Signature	School Child Attends	Date