B-816

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 _____