Medication Administration Consent and
Licensed Prescriber Order
Smethport Area School District

Student Name: _____ Date/Time: _____

School: ❒ Elementary School ❒ High 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:** _____

Reason for medication: _____

Name of medication: _____

Route and dosage: _____ **Time of administration:** _____

Directions: _____

_____

Discontinuation date: _____ **Allergies:** _____

Licensed prescriber name printed: _____ **Phone:** _____

Licensed prescriber signature: _____

Elementary School Nurse:
Amy Costa RN, BSN, CSN
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High School Nurse:
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