Crawford Central School District
Department of Health Services

Medication Administration Consent And
Licensed Prescriber Order

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 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 or packaging.

Parent/Guardian Consent:

I give my permission for my child, _____, to receive the prescribed medication set forth below 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 & 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 the school nurse.

Parent/Guardian signature: _____ Date: _____
Parent/Guardian name print: _____ Phone: _____

Licensed Prescriber Medication Order:

Patient's name: _____ Date: _____
Name of medication: _____
Route and dosage: _____
Time of administration: _____
Directions: _____
_____
Discontinuation date: _____
Allergies: _____

Student may **SELF-MEDICATE*** this medication at school: **YES** or **NO**
*For use of Asthma Inhalers 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 print: _____ Phone: _____