North Clarion County School District
High School (814)744-8544 · Fax (814)744-8762
Elementary (814)744-8541 · Fax (814)744-9229

School Medication Administration Authorized Prescriber Order & Parental Consent

Student's Name: _____ Date of Birth: ____/____/____ School Year: ____/____

School: _____ Grade: _____ Homeroom: _____

Authorized Licensed Prescriber Order

Name of Child/Student: _____ Date of Birth: ____/____/____ Today's Date:____/____/____

Medication Name: _____ Controlled Drug? □Yes □No

Condition for which medication is being administered: _____

Dosage: _____ Route: _____ Time of Administration: _____

Specific Instructions for Medication Administration: _____

Relevant side effects of medication: _____ □None expected

Discontinue Date:____/____/____ Allergies: _____

May the student self administer this medication*? □Yes □No □N/A

*** (Applies to inhalers, diabetic medications and Epinephrine Auto Injectors ONLY)**

Prescriber's Name/Title: _____ Phone: _____

Prescriber's signature: _____ Date: _____

Parent/Guardian Consent

I give permission for my child, _____, to receive the following medication ordered by a licensed healthcare provider during the school day. I understand that the medication will be given at the school nurse's/healthcare technician's discretion. I understand that in accordance with school policy, medication should be given at home when possible. However, when this is not possible, prior to receiving any medication (prescription or over-the-counter) during the school day, a licensed healthcare provider must provide a written order/prescription to the school. ALL medications must be brought in by a parent/guardian, in the original pharmacy prescription bottle/packaging labeled with the child's name, medication name, dose and directions for administration. All medications are to be kept in the school health office, unless indicated otherwise by my child's healthcare provider.

Parent/Guardian Name: _____ Signature: _____ Date: _____