

LAMPETER-STRASBURG SCHOOL DISTRICT

1600 Book Road – P. O. Box428
Lampeter, Pennsylvania 17537

Medication Administration Consent Form

Student Name: _____ Birthdate: _____

School: _____ Grade/Teacher: _____ School Year _____

THIS SECTION IS TO BE COMPLETED BY THE PARENT/GUARDIAN

We discourage the administration of medication during school hours or during school events. However, if your medical provider decides it is necessary for your child to receive a medication during the school day or other school event, his/her approval and specific directions must be provided to the school. The PA State Law and the medication policy of Lampeter-Strasburg School District requires the written order of a physician/dentist/CRNP/PA's and the written authorization of the parent/guardian for a nurse to administer both over the counter (OTC) or prescription medications.

Medications must be in the original container for OTC or in a properly labeled, pharmacy-prepared container with the following information: Name, Address, Telephone and Federal DEA (Drug Enforcement Agency) Number of the Pharmacy; Student's Name, Directions for Use (dosage, frequency and time of administration, route, special instructions); Name and Registration Number of the Licensed Prescriber; Prescription Serial Number; Date Originally Filled; Name of Medication and Amount Dispensed.

- To protect your child and other students, the student may not keep medication with them unless they have permission to self-carry **emergency medications only** (asthma Inhaler or epinephrine pen only).
- In compliance with School Board Policy, all medication must be brought to the main office by the parent/guardian or by another designated adult for delivery to the nurse.
- Both parent and physician signatures are required to permit the nurse to administer the medication.
- Students are expected to come to the Health Room at the appropriate time to take their medication.
- Parent/guardian will notify the school of any change in medication and provide a new medication administration consent form.
- Parent/guardian must come to school to pick up any medication that has been discontinued. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of the school year.
- The School Nurse has permission to consult with the below named licensed prescriber regarding any questions that arise with regard to the listed medications or medical conditions being treated by the medication.
- School personnel will not be held liable in the event of adverse reactions resulting from taking this medication(s).

Parent Signature _____ Date _____

The following sections are REQUIRED to be COMPLETED by the prescribing health care provider.

Diagnosis	Medication	Dose	Frequency	Route	Side Effects

Physician Name (print): _____ Physician Signature: _____

Office Number: _____ Fax Number: _____ Date _____

****This section is REQUIRED in order for student to carry and self-administer an inhaler or epinephrine pen****

- Student should carry and self-administer his/her **asthma inhaler** _____ **epinephrine pen** _____
- As the health care provider for this student, I verify that he/she has been taught proper use of his/her inhaler and/or epinephrine Pen, has adequate knowledge of asthma/anaphylaxis and how to control it, and is thought to be responsible enough to carry his/her inhaler/Epinephrine pen and use it without supervision.
- As the health care provider, I have completed and reviewed with student and parent/guardian, an emergency plan of care.

Provider Signature: _____ Date: _____

For Inhaler and Epinephrine Only: I give my permission for my child to carry and self-administer his/her prescribed: Asthma Inhaler Yes _____ No _____ Epinephrine Injection Yes _____ No _____

Parent Signature _____ Date _____

Student's self-administration of inhaler and/or epinephrine pen approved by: _____