AVONWORTH ELEMENTARY SCHOOL

1320 Roosevelt Road
Pittsburgh PA 15237
412-366-7170
Fax: 412-366-4146
"Large Enough to Matter, Small Enough to Care"

Medication Administration Consent & Licensed Prescriber Order

Student Name: _____ Date/Time: _____

School:_____ Teacher/Grade:_____

In accordance with school procedure, 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. This includes over-the-counter medication. ALL medications must be in an original prescription bottle/container from a pharmacy. Over-the-counter medications must be in the original, unopened package. **The pharmacy label may be used instead of the signed prescription only if the dose and administration instructions are exactly as stated on the prescription.**

Parent/Guardian Consent:

I give my permission for my child, _____, to receive the following medication ordered 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:_____

Physician / Licensed Prescriber Medication Order:

Patient's name:_____Date:_____

Name of medication:_____

Reason for Administration:_____

Route and dosage:_____

Time of administration:_____ Discontinuation Date:_____

Directions/Precautions or Special Instructions:_____

_____

Allergies:_____

Licensed Prescriber signature:_____ Phone:_____
Printed Name: _____