Dover Area School District
Medication Administration Consent & Licensed Prescriber Order

Student Name:_____ Date:_____

School:_____ Teacher/Grade:_____

In accordance with School Board Policy #210, 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.

****PHYSICIAN: PLEASE INITIAL APPROPRIATE SELECTION BELOW FOR ALL DAILY OR EMERGENCY MEDICATIONS (INHALER, EPIPENS, ETC)****

During field trips the medication noted above will:

_____ 1. Be omitted the day of the trip.

_____ 2. Be given before/after field trip during regular school hours

_____ 3. Be administered by parent/guardian accompanying student on trip.

_____ 4. Be self-administered on field trip by student (Grades 7-12) under direct supervision of district staff member. The parent/guardian will provide a properly labeled, original medication container from the pharmacy that includes only the amount of medication that will be needed for the trip including EpiPens and inhalers.

****PHYSICIAN: PLEASE INITIAL APPROPRIATE SELECTION BELOW REGARDING SELF ADMINISTRATION OF INHALER/EPIPEN IN SCHOOL****

_____The student **has permission** to carry and self-administer an asthma inhaler/EpiPen during schools hours. This student is qualified and has demonstrated the ability to self-administer an asthma inhaler/EpiPen.

_____The student **DOES NOT have permission** to carry and self-administer an asthma inhaler/EpiPen during school.

_____ _____
(Signature of Attending Physician) **(Date)**

_____ _____
(Address of Attending Physician) **(Phone/Fax No. of Physician)**

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Licensed Prescriber Medication Order:

Patient's name:_____ **Grade:**_____

Name of medication:_____

Dosage:_____

Time of administration:_____

Approximate Length of Time:_____

Specific Instructions:_____

_____

Licensed Prescriber signature:_____

Licensed Prescriber name printed:_____ Phone #:_____

Date of Order:_____

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:_____