# HOPEWELL AREA SCHOOL DISTRICT

HOPEWELL HIGH SCHOOL

1215 LONGVUE AVENUE
ALIQUIPPA, PENNSYLVANIA 15001-4206

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MICHAEL E. ALLISON
PRINCIPAL

DOUGLASS C. ROWE
ASSISTANT PRINCIPAL


## Medication Administration Consent Order Form

**Student Name** _____ **Date**_____

**School** _____ **Grade**_____

**The Hopewell Area School District policy for administration of medication is as follows:**

**Prescription Medication**: I understand that prescription medication must be in the container in which it was purchased; and the name of the medication, the dosage and the times to be given, the licensed prescriber/physician's name must be printed on the container, along with an order from the licensed prescriber/physician and consent of the parent/guardian.

**Over-the Counter Medication-** I understand that over-the- counter medication (such NSAIDS, antacids, cough medication) must be provided by the parent, in the original container, along with an order from the licensed prescriber/physician and consent of the parent/guardian.

All medication should be taken by the parent/guardian directly to the certified school nurse to be stored throughout the day. Please contact your schools' certified nurse if you require special consideration. **No medication will be administrated without the completion of this form and the signatures of the parent /guardian and licensed prescriber/physician.**

I give permission for the licensed certified school nurse/licensed health personnel to contact the licensed prescriber/physician or pharmacist regarding this medication.

## Parent/Guardian Consent

I give my permission for my child, _____, to receive the following medication ordered by a licensed prescriber/physician during the school day. I understand that the medications will be given by licensed certified school nurse/licensed health personnel according to my child's licensed prescriber/physician's order.

**Parent /Guardian Signature**_____**Date**_____

**Parent /Guardian Name(Printed)**_____**Phone#** _____

**OVER** ➡

# Licensed Prescriber/Physician Medication Order

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 certified school nurse with a Medication Administration Consent Order form annually signed by the student's parent/guardian and a licensed prescriber/physician.

**Patient/Student Name** _____ **Date**_____

**Name of medication:** _____

**Dosage:** _____ **Route: Oral**_____ **Injection**_____ **Inhalation**_____ **Other**____

**Time of administration:** _____

**Reason for Medication:** _____

**Discontinuation date:** _____

**Allergies:** _____

**Side Effects or contraindications:**_____

***The above student has demonstrated the ability to self-carry and/or self-administer the prescribed Asthma inhaler and/or Epinephrine Auto-Injector medication.***

**Yes**_____ **No**_____

**Licensed Prescriber Name (Printed)**_____

**Licensed Prescriber Signature** _____ **Date**_____

**Phone#** _____