PENN-TRAFFORD SCHOOL DISTRICT
MEDICATION ADMINISTRATION PERMISSION FORM
(For Possession and Use of Asthma Inhalers and Epinephrine Auto-Injectors)

Student Name _____ Grade _____

School _____ HR Teacher _____

Medications should be given at home whenever possible. If medication must be given at school, **both** a written order from the child's physician and a written consent form from the parent/guardian must be submitted for ***all*** medication, ***prescriptive and over the counter***. In order for your child to receive *any* medication at school, this form must be completed in its entirety and returned to the certified school nurse.

Medication is limited to thirty (30) doses. All medications must be brought to the certified school nurse in their original container that is appropriately labeled by the pharmacy or physician.

A. Parental/Guardian Consent

I give permission for my child, _____, to self-administer the following medication ordered below by a licensed prescriber during the school day. I release the Penn-Trafford School District and its employees of any responsibility for the benefits or consequences of this medication and acknowledge that the school entity bears no responsibility for ensuring that the medication is taken.

Parent/Guardian Signature: _____ Date _____

Parent/Guardian Printed Name: _____ Phone _____

B. Licensed Prescriber Medication Order

Student Name _____ Date _____

Medication _____ Route/Dosage _____

Time of Administration _____ Discontinuation Date _____

Allergies _____

Other medications currently being taken _____

Licensed Prescriber Signature _____

Prescriber Name Printed _____ Phone _____

3.21.2012