

PENN-TRAFFORD SCHOOL DISTRICT  
MEDICATION ADMINISTRATION PERMISSION FORM

Student Name \_\_\_\_\_ Grade \_\_\_\_\_

School \_\_\_\_\_ 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 for controlled substances and five (5) doses for other prescribed medications. 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 receive the following medication ordered below by a licensed prescriber during the school day. I understand the medication will be given by the certified school nurse or the designated registered nurse.

Parent/Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Printed Name: \_\_\_\_\_ Phone \_\_\_\_\_

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**B. Licensed Prescriber Medication Order**

Student Name \_\_\_\_\_ Date \_\_\_\_\_

Medication \_\_\_\_\_ Route/Dosage \_\_\_\_\_

Time of Administration \_\_\_\_\_ Discontinuation Date \_\_\_\_\_

Allergies \_\_\_\_\_

Licensed Prescriber Signature \_\_\_\_\_

Prescriber Name Printed \_\_\_\_\_ Phone \_\_\_\_\_