BROCKWAY AREA SCHOOL DISTRICT
MEDICATION ADMINISTRATION CONSENT FORM

All students using **inhalers or epi pens** in school must have this form signed by the student's parent/guardian AND the licensed prescriber. A new order/signature is needed each school year. All medications will be kept in the nurse's office and will be administered by the school nurse *unless* designated by the physician to be carried by the student. Staff members are trained to administer Epi Pens, and will be required to do so in an emergency.

Student's Name: ________________________Date of Birth: _______ Grade: ____ Date:_______

Name of Medication: _______________________________ Dosage: ________________

Time to be administered: ____

Purpose: ____

Termination date: ____________________________________(limit of one school year)

Possible side effects:

____

____

Procedure to follow if reaction occurs:

____

Curtailment of specific activity (sports, shop, gym, etc.):

____

___________________________	______________________	___________	_________
Licensed Prescriber Signature	**Print Name**	**Telephone**	**Date**

Permission to self- carry and administer? ____________________________
Licensed Prescriber Signature

___________________________________ ________________________
Parent Signature **Date**

___________________________________ ____________________________________
Principal Signature **School Nurse Signature**

*The school nurse will supervise the **self-administration** of this medication but is not responsible for documenting when medication is administered if the student does not report its use. If no **self-administration** signature/order is given from the prescriber and the medication is found with the student in school, it will be removed from the student's possession and disciplinary action may be taken.