Eastern Lancaster County School District
669 East Main Street, New Holland, PA 17557

Medication Administration Consent Form

Medication should be ordered to be given to a student at school ONLY WHEN ABSOLUTELY NECESSARY. Whenever possible, the parent and Licensed Health Care Provider are urged to design a schedule for giving medication outside of school hours. If this is not possible, designated school personnel will dispense the medication. Prescription medication must be furnished in the original container, labeled with the name of the medication, the amount to be taken, frequency of administration, the name of the physician, and the name of the child. Any medication which comes under the law of controlled substances (such as Ritalin) must be delivered by the parent to the school nurse. Over the counter medication is to be furnished in the original container with the label, directions and expiration date clearly legible. All medications are kept in the nurse's office. Students are expected to come to the health room at the appropriate time to take their medicine. This authorization is good for the current school year only. Unused medication should be collected from the school. Any uncollected medicine will be destroyed at the end of the school year or at the end of the prescribed duration of administration, whichever is sooner. The taking of medications is a serious health concern, and your cooperation in following the above guidelines to insure your child's health is appreciated. Please have all sections completed and return this form when your child needs to take medication at school.

Medication order to be completed by licensed prescriber:

Name of Student _____ Birth Date _____ Grade _____
School _____ School Year _____ HR _____

Medical Condition/Diagnosis _____

Medication	Dosage	Frequency and Time(s)	Route	Side Effects

Additional Considerations/Directions _____

Student may carry and is capable of self-administration (limited to inhalers/Epi-Pens/Insulin/Glucagon): ☐No ☐ Yes

_____ _____
(Print) Name of Physician/Licensed Prescriber Signature of Physician/Licensed Prescriber

_____ _____
Phone Number Date

To be completed by parent/guardian:

1. I request that the above medication be given during school hours as ordered by this student's licensed prescriber. The nurse may administer or decline to administer a medication based on best nursing practice. Students who carry and self- administer must successfully complete the self -medication assessment form with the ELANCO nurse.
2. I release school personnel from liability in the event of adverse reactions resulting from taking the medication.
3. I will notify the school of any change in the medication in writing from the licensed prescriber and a new form completed.
4. I give permission for the school nurse to communicate with the student's teachers about the student's health condition and the action of the medication.
5. I give permission for the school nurse to consult with the above named licensed prescriber regarding any questions that arise with regard to the listed medication or the medical condition being treated by the medication(s).

_____ _____
Date Parent/Guardian Signature

For Health Room Use Only

Signature/Initials:

_____
_____
_____
_____

Date:	Date:	Date:	Date:	Date:	Date:

Date:	Date:	Date:	Date:	Date:	Date: