Union Area School District

2106 Camden Avenue • New Castle, Pennsylvania 16101 • ☎ 724-658-4501 • FAX 724-658-8617

ROB J. NOGAY, MEd, Middle/High School Principal

Medication Administration Consent & Licensed Prescriber Order

TO BE COMPLETED BY PHYSICIAN AND PARENT

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 school nurse with a Medication Administration Consent form signed by the student's parent/guardian and a Medication Order from a licensed prescriber. All medications must be in an original prescription container from a pharmacy. Complete one form per each medication to be administered.

Licensed Prescriber Medication Order (Must be completed by Physician or a written Physician order obtained).

Student Name:_____Grade:_____

Building:_____

Name of Medication:_____Dosage:_____

Reason for Medication:_____Route:_____

Time to be administered:_____Date(s) to be administered:_____

Side effects/procedure if an adverse reaction should occur:

_____

List all medication student is currently taking:_____

Allergies:_____

Limitation of school activity: No____ Yes____Please specify:_____

Please choose an option below for when a nurse/parent/guardian is unable to attend a field trip:

_____Yes, the prescribed dose can be withheld/time adjusted upon return to school.

_____No, this medication must be given to the child at the prescribed time.

Prescriber name:_____Prescriber phone number:_____

Prescriber signature:_____

Action Plans completed by Parent/Guardian/Student: ____Diabetes Action Plan

_____Asthma Action Plan____Allergy/Anaphylaxis Emergency Care Plan____Seizure Action Plan

Name of Parent/Guardian:_____

Signature of Parent/Guardian:_____

Signature of School Nurse:_____Date:_____