Lowell Area Schools
Medication Administration Consent Form

Student: _____ Today's Date: ____/____/____ School Year: _____

DOB: ____/____/____ Age: _____ Grade: _____

❑ Form Reviewed by District Nurse: _____

This form must be completed fully in order for schools to administer the required medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication.

- Prescription medication must be in a container labeled by the pharmacist or prescriber
- Non-prescription medication must be in the original container with the label intact.
- An adult must bring the medication to the school.
- The school nurse will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.
- Expired medication will not be accepted.

Medication – Prescription and OTC **This section MUST be completed by the PARENT/GUARDIAN**

"Medication" refers to any prescription, OTC, herbal, homeopathic, vitamins or minerals.

Name of Medication: _____ Reason for Use: _____

Dosage (mg/ml): _____ Medication Route: ❑Oral ❑Inhalation ❑Injection ❑Other _____

Instructions (specify time taken): _____

Parent/Guardian Signature _____ **Relationship** _____ **Date** ____/____/____

Authorization also includes permission for school personnel and/or health care provider to contact each other as needed. Medication and Treatment information is kept confidential but may be shared with appropriate school staff, administration,health care personnel, or emergency services.

Medication – Prescription and OTC **This section MUST be completed by PHYSICIAN**

My signature below indicates the above medication information is correct as prescribed

Physician's Name (Printed): _____ **Phone:** _____

Physician's Signature: _____ **Date:** ____/____/____

ONLY IF APPLICABLE – Self carry/administer medication – Emergency Medication ONLY

*Student is capable and responsible for **self-administering** the above prescription: ❑Yes-Unsupervised ❑Yes-Supervised ❑No

Physician's Name (Printed): _____ **Phone:** _____

Physician's Signature: _____ **Date:** ____/____/____

I give permission for my child, _____, to ❑self-administer ❑self-carry the above medication at school.

Parent/Guardian Signature _____ **Relationship** **Date** ____/____/____

Medication Received By: _____ **Date:** ____/____/____

Medication is Located (Specify Exact Location): _____