

SCHOOL DISTRICT OF HATBORO-HORSHAM- SCHOOL HEALTH SERVICES

PERMISSION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

In order for the school nurse to administer medications in school, this form must be completed and returned to the school nurse with the medication. The medication must be in the original container and be properly labeled with your child's name, medication name, date, dosage and time to be administered.

**CONTROLLED, PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS**

STUDENT'S NAME: \_\_\_\_\_ GRADE: \_\_\_\_\_

REASON FOR MEDICATION: \_\_\_\_\_

MEDICATION: \_\_\_\_\_

DOSAGE: \_\_\_\_\_ TIMES TO BE GIVEN: \_\_\_\_\_

DATES TO BE GIVEN: \_\_\_\_\_

PHYSICIAN SIGNATURE: \_\_\_\_\_

PARENT SIGNATURE: \_\_\_\_\_

**FOR INHALER AND EPI-PEN PRESCRIPTIONS- SELF CARRY OPTION**

This student has been instructed and has demonstrated competency in the use of his/her inhaler/Epi-Pen and may self-administer this medication as needed in school.

PHYSICIAN SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_