



# POTTSTOWN SCHOOL DISTRICT

ADMINISTRATION BUILDING • 230 Beech Street • Pottstown PA 19464 • (610)323-8200 • FAX (610)326-6540

www.pottstownschoools.org

**Our Mission: *Prepare each student, by name, for success at every level.***

## AUTHORIZATION FOR SCHOOL MEDICATION ADMINISTRATION

Student Name: \_\_\_\_\_ Date/Time: \_\_\_\_\_

School: \_\_\_\_\_ Teacher/Grade: \_\_\_\_\_

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 bottle/container from a pharmacy.

Parent/Guardian Consent: I give my permission for my child, \_\_\_\_\_, to receive the following medication ordered by a licensed prescriber during the school day. I understand that the medications will be given by school health personnel according to my child's licensed prescriber's directions.

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian name printed: \_\_\_\_\_ Phone: \_\_\_\_\_

-----  
**Licensed Prescriber Medication Order:**

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Route and dosage: \_\_\_\_\_

Time of administration: \_\_\_\_\_

Directions: \_\_\_\_\_

Discontinuation date: \_\_\_\_\_ Allergies: \_\_\_\_\_

Licensed Prescriber signature: \_\_\_\_\_

Licensed Prescriber name printed: \_\_\_\_\_ Phone: \_\_\_\_\_

**\*\*Please review other side**

## **ADMINISTRATION OF MEDICATION**

A parent/guardian or a responsible adult designated by the parent/guardian should deliver all medications to the school. The medication must be in the original over-the-counter or pharmacy labeled bottle.

Prescription medication labels must contain:

- Name, address, telephone number and Federal DEA (Drug Enforcement Administration) number of the pharmacy
- Patient name
- Directions for use (dosage, frequency and time of administration, route, any special instructions)
- Name and registration number of the licensed prescriber
- Prescription serial number
- Date originally filled
- Name of medication and amount dispensed
- Controlled substance statement, if applicable

Medications in plastic bags or containers other than their original pharmacy container are **NOT** acceptable.

At the end of each school year, a parent/guardian or a responsible adult designated by the parent/guardian should pick up all unused medications.

**Medication should be scheduled around school hours if possible. Medication orders are required from a physician for prescription and over-the-counter medicine, as well as herbal remedies. The order from the physician must include:**

- Student's name
- Name, signature, and phone number of the licensed prescriber
- Name of medication
- Route and dosage of medication
- Frequency and time of medication administration
- Date of the order and discontinuation date
- Specific directions for administration if necessary

**\*\*\*A new prescription is needed EVERY school year for medicine that is taken on a long term basis. Physicians' orders do not carry over from one school year to the next. They are good for one school year and summer only.**