MEDICATION ADMINISTRATION CONSENT & PRESCRIPTION
Brentwood Borough School District

Student Name: ___________________________________ Birth date: ____________________

School: _______________________________________ 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.

<u>All medications must be in an original prescription bottle/container from a pharmacy.</u>

Parent/Guardian Consent

I give my permission for my child, as named above, to receive the following medication during the school day as ordered by a licensed prescriber. I understand that the medication(s) 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: __________**