

# SCHOOL DISTRICT OF CHELTENHAM TOWNSHIP

---

## ADMINISTRATION BUILDING

2000 Ashbourne Road • Elkins Park, PA 19027-1100 • 215-886-9500 • Fax: 215-884-6929

DARLENE G. DAVIS, Ed.D., Superintendent  
MICHAEL LOWE, Ed. D., Assistant Superintendent

---

### **Medication Administration Physician Order & Parental Consent**

**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. All medications must be delivered in person by the student's parent/guardian, per School Board policy 210.2H.

#### **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 & dosage: \_\_\_\_\_ Time of administration: \_\_\_\_\_

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

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

Allergies: \_\_\_\_\_

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

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