MSAD #49
Medication Administration Consent Form

Procedure:

A. Parent/Guardian authorization/consent form (see below) must be obtained prior to administration of any medication at school. This must include the child's full name, name of medication, date, and dosage time(s).

B. Any prescription medication needed for more than 15 consecutive days requires a current **written order** from the prescribing health care provider. A prescription label on the medication package is sufficient for any other prescription medications.

C. **All over the counter medications must be accompanied by a current physician's order except Acetaminophen and Ibuprofen, as the use of these common pain relievers in school has been approved by our district physician.**

D. The student's parents/guardian shall deliver any medication to be dispensed at school. It must be in its original, labeled container. In the event that this is not practical, it is the parent's /guardian's responsibility to contact the school to make alternative arrangements.

E. The first dose of any medication must be given at home. Parents are encouraged to teach their child about their medication: its purpose, how to take it properly and when to take it.

F. Medications will be administered by the school nurse or by the school nurse's designee. This may include medically unlicensed personnel.

G. Information regarding the student's medication may be shared with appropriate school personnel.

H. Exceptions to the above may be requested by a physician. The school nurse and the principal will be informed.

Parent/Guardian Consent

Please allow my child _____, Grade _____ to take

Name of Medication _____.

Amount to be given _____at_____(Time)

Reason for taking this medication is: _____.

_____ _____

Parent Signature Date

***** Please see other side for information about emergency medications** Rev. 1/2014

Maine Law permits students to carry and use inhaled medicines and Epi-pens with parent and physician approval and competency assessment by the school nurse

( ) I authorize the exchange of medical information about my child's health condition between the physician's office and school nurse

( ) My child may carry an emergency medication (asthma inhaler or epinephrine) and self-administer if necessary.

( ) My child may not carry an emergency medication and it will be stored in the office.

PARENT SIGNATURE: _____ **DATE:** _____

**The school nurse shall evaluate the student's technique to ensure proper and effective use of an asthma inhaler or an epinephrine pen in school.

TO BE COMPLETED BY PHYSICIAN

1. Student Name: _____ DOB: _____
2. Medication, dosage and time: _____
3. Reason for medication: _____
4. Duration of medication: _____
5. Significant side-effects: _____
6. The student has the knowledge and skills to safely possess and use an inhaler and/or epinephrine auto-injector. ( ) Yes – Agree
   ( ) No – Do not agree

Provider's Name: _____

Provider's Signature: _____ Date: _____

Phone Number: _____