COUNCIL ROCK SCHOOL DISTRICT
School Health Services

PERMISSION TO ADMINISTER MEDICATIONS IN SCHOOL

The following to be completed by the licensed prescriber

Patient's name _____ Date _____

Name of medication _____

Dosage _____ Time to be given _____ Route _____

Reason for Medication/Treatment _____

Directions _____

Effective date's _____ to _____

Allergies _____

It is my understanding that the employees of the Council Rock School District charged with the administration of this treatment/procedure during school hours may rely on directions contained in this document. I further certify that I am the physician/dentist who prescribed the treatment/procedure and that the student named above is under my supervision as a patient.

☐ **It is my professional opinion that this child should carry his/her prescribed medications (CIRCLE ONE: Inhaler, EpiPen, Diabetic Medications) by him/herself**

Licensed Prescriber signature _____

Licensed Prescriber printed name _____

Licensed Prescriber telephone number _____

Parent/Guardian Consent

I give my permission for my child, _____, to receive the following medication ordered by a licensed prescriber during the school day and release the Council Rock School District and its employees from liability for any damages my child may suffer because of this request. 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:** _____