Student: _____ Grade: _____ School Year: _____
Last name First Name

Allegheny Valley School District
Medication Administration Consent Form

Before any medication (prescription and non-prescription) may be administered to or by any student during school hours, the Board requires written communication from the licensed provider and also the written request of the parent/guardian. This medication Administration Consent Form must be completed and accompany the prescribed medication. All medications, prescription and over the counter, must be in an original prescription bottle/container from a pharmacy.

Physician recommendation and order for medication administration:

Please be advised that _____is currently under

my care for the diagnosis of _____.

Therefore it will be necessary to administer the following medication during school hours:

Name of medication: _____

Route and Dosage: _____ Time of administration:_____

Possible side effects: _____

Discontinuation date: _____

***It is necessary for this student to carry and self-administer this medication during the school day:**
YES NO

_____ _____
Physician Signature Date

_____ _____
Physician name printed Physician phone number

Parent/Guardian:

Please provide this medication for my child as directed by his/her physician. I understand that a licensed medical professional will administer this medication. In the event that the nurse is not in the building, the medication will be taken in the presence of the Principal or his/her designee.

_____
Parent Signature Date