Union City Area School District

107 Concord Street
Union City, Pennsylvania 16438

www.ucasd.org

(814) 438-3804
Fax: (814) 438-8463

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.

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:_____

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Licensed Prescriber Medication Order:

Patient's Name: _____Date_____

Name of Medication: _____

Route and Dosage: _____

Time of Administration: _____

Directions: _____

Is child authorized to self-medicate? _____

Discontinuation Date: _____

Allergies: _____

Licensed Prescriber Signature: _____

Licensed Prescriber Name Printed: _____Phone: _____