Union School District

Union High School
354 Baker St., Suite 1
Rimersburg, PA 16248
Ph: (814)473-3121
Fax: (814)473-8201

Sligo Elementary
2013 Madison St. Ext.
Sligo, PA 16255
Ph: (814)745-2152
Fax: (814)745-3017

Medication Administration Consent at School

School: ___ Union High School ___ Sligo Elementary

Student Name: ____ Grade: _______________

Name of Medication: ____

Dosage, Route, and Time medication is to be given: _______________________________________

Date Prescription Begins: ______________________________ Ends: _________________________

Special Instructions, if any: (pills crushed, with water, etc.) _____________________________

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Possible Reactions that may occur: ____

Procedures to follow if reaction occurs: ____

For students prescribed EpiPens and/or Inhalers: This student is capable of carrying his/her epipen/inhaler with them at all times and may self-administer as prescribed: Yes ____No ____

If you wish to request the Union School District to administer medication to one of your patients, please complete ALL items listed above and return to the school by mailing or faxing as indicated above or give the completed form to the parent to present to the school upon their child's return to school. Requests for the administration of medication are only valid for the medication listed and the date indicated in writing on the request form. Requests are valid for a maximum period of one year, not past the end of this school year.

Physician Signature: ____ Date: ___________

Physician Name Printed: ____ Phone: ____________

I certify that I am the parent, legal guardian, or person in legal control of the above named student. I request and authorize Union School District to administer the above medication to the above student in accordance with the prescription and instructions of the student's physician or dentist. I understand that administration of medication will commence when the parent/guardian and physician/dentist requests are received and reviewed by authorized district personnel.

I agree, in the absence or unavailability of the school nurse, the nurse will designate other appropriate personnel (RN, LPN). By signing this form I authorize the school nurse to contact the prescribing physician with questions/concerns regarding the medication.

I do hereby release, discharge, and hold harmless Union School District and employees from any and all liability and claim whatsoever for the administration of the above medication to my child/ward should he/she develop an allergic or other reaction from the medication.

Parent/Guardian Signature: ____Date: _________

Parent/Guardian Name Printed: ____ Phone: _________