

PENN-DELCO SCHOOL DISTRICT

Permission to Administer Medications

Student Name: _____ DOB _____

Grade: _____ School: _____

TO BE COMPLETED BY HEALTH CARE PROVIDER

Diagnoses: _____

Medication Name	Dose	Route	Time

Name and Title of Licensed Prescriber (please print) _____

Licensed Provider's Signature _____ Date _____ Phone _____

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for the above medication(s) to be administered to my child as ordered by my health care provider. I will furnish the medication in the original pharmacy container, properly labeled with directions and dosage.

Parent/Guardian Signature _____ Date _____ Phone _____

SELF ADMINISTER/SELF CARRY INHALERS AND EPI PENS ONLY

Self Administer/ Self-Carry Inhalers/Epi-Pens only	<p>1) I have determined this student is consistent and responsible in taking their own medications (self-directed) _____ yes _____ no</p> <p>2) I give them permission to self-carry and self-administer these medications. They will be considered independent in medication delivery and need intervention only during emergencies _____</p> <p>*Penn Delco School District will not be held responsible for ensuring that the medication is administered</p>
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Licensed Provider's Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

School Nurse _____ School: _____