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	1) I have determined this student is consistent and responsible in taking their own medications (self-directed) _____**yes** _____**no** 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 _____ ***Penn Delco School District will not be held responsible for ensuring that the medication is administered**

Licensed Provider's Signature _____ **Date** _____

Parent/Guardian Signature_____ **Date**_____

School Nurse_____ **School:** _____