Dauphin County Technical School 6001 Locust Lane, Harrisburg, PA 17109 Phone: (717) 652-3170, ext. 7439 Fax: (717)652-0526

## **Private Physician's Request to Administer Medication During School Hours**

In accordance with school policy, medications should be given at home before and/or after school. However, when this is not possible, prior to receiving medication at school, <u>each student</u> 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 prescriptions 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 schoo	l day. I understand that the
medications will be given by the school health personnel according my	child's licensed prescriber's
directions.	

Parent/Guardian Signature: \_\_\_\_\_\_Date: \_\_\_\_\_Date: \_\_\_\_\_Date: \_\_\_\_\_Date: \_\_\_\_\_Date: \_\_\_\_\_Date: \_\_\_\_\_\_Date: \_\_\_\_\_Date: \_\_\_\_\_\_Date: \_\_\_\_\_Date: \_\_\_\_\_Date: \_\_\_\_\_\_Date: \_\_\_\_\_\_\_Date: \_\_\_\_\_\_Date: \_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_Date: \_\_\_\_\_D

## **Licensed Prescriber Medication Order**

Patient's Name:	Date:	
Name of Medication:		
Route and dosage:		
Time of Administration:		
Directions:		
Discontinuation date:		
Allergies:		
Licensed Prescriber signature:		
Licensed Prescriber name printed:	Phone:	