

# Reading Public Schools

## MEDICATION ADMINISTRATION ORDERS AND CONSENT FORM

Name: \_\_\_\_\_ Grade: \_\_\_\_\_ D.O. B. \_\_\_\_\_  
Address: \_\_\_\_\_ Sex: M/F

**Allergies** \_\_\_\_\_

Diagnosis: \_\_\_\_\_

**1. Medication:** \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Date of Order: \_\_\_\_\_ Time of Administration: \_\_\_\_\_ Route: \_\_\_\_\_

**2. Medication:** \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Date of Order: \_\_\_\_\_ Time of Administration: \_\_\_\_\_ Route: \_\_\_\_\_

**3. Medication:** \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Date of Order: \_\_\_\_\_ Time of Administration: \_\_\_\_\_ Route: \_\_\_\_\_

To be completed if not in violation of confidentiality:

Please list all medications the child is receiving, including those given during and after school hours.

Please include adverse reactions and side effects and any known allergies.

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Signature of Physician: \_\_\_\_\_

Phone # \_\_\_\_\_ Date \_\_\_\_\_

### PARENTAL CONSENT

\_\_\_\_ 1. I give my permission to have the school nurse administer the medication ordered above.

\_\_\_\_ 2. I give permission for my son/daughter to self-administer only inhalers and/or epi-pens at school and /or on field trips with physician's signature.  
(Grades 5-12 only)

\_\_\_\_ 3. I give permission to the school nurse to share with appropriate school personnel, information relative to this student's health status.

\_\_\_\_ 4. I authorize a teacher or chaperone deemed qualified by the school nurse to administer this/these medications on field trips. (N/A RMHS).

Please note: I understand that I may retrieve the medication from the school at any time, and that the medicine will be destroyed if it is not picked up following termination of the order or beyond the close of school.

Parent/Guardian (please print): \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_ Date: \_\_\_\_\_

Telephone number: \_\_\_\_\_

Emergency number: \_\_\_\_\_

Revised 6/06