*K*iski Area School District
200 Poplar Street, Vandergrift, PA 15690

Medication Administration Consent &
Licensed Prescriber Order

In order for any prescription or over-the counter medication to be administered during school hours, the following must be provided to the Certified School Nurse:

- **Parent Consent for Medication Administration** (see below)
- **Licensed Prescriber Medication Order** (see below)
- Medication
  - In original prescription bottle or over-the counter container
  - Brought to the school by an adult

Parent Consent for Medication Administration

Student Name: _____ Date of Birth:____/____/_____

Grade/Homeroom: _____

Medication(s): _____

FOR RESCUE INHALERS ONLY:
In the case that a student is permitted to carry and self-administer his/her own rescue inhaler, Kiski Area School District and its employees will not be responsible for either the benefits or consequences of medication use, nor will we be able to ensure that the medication is taken.

The student must demonstrate to the School Nurse that he/she is able to self-administer the rescue inhaler.

_____**(Please initial): I permit my child to carry his/her own rescue inhaler.**

Parent/Guardian signature: _____ Date: ____/____/_____

Parent/Guardian name printed: _____ Phone: _____

****Licensed Prescriber Medication Order** should be attached and include:

- Letterhead of prescriber's practice
- Student name
- Medication name
- Route
- Dosage
- Frequency/scheduled time
- Other pertinent information
- Prescriber's signature (MD, DO, OD, PA, or CRNP)
- Date