Oxford Area School District

Student Name :_____ Date/Time_____

School:_____Teacher/Grade _____

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 the medication at school, each student 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 prescription 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 school day. I understand that the medication will be given by school health personnel according to my child's licensed presciber's directions.

Parent/Guardian signature:_____ Date: _____

Parent Guardian name printed: _____ Phone: _____

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: _____

Oxford Area School District

Nombre del estudiante:_____ Fecha/hora:_____

Escuela:_____Maestro/grado:_____

De acuerdo con la política escolar, los medicamentos se deben administrar en la casa antes o después de la escuela. Sin embargo, cuando esto no es posible, antes de recibir el medicamento en la escuela, cada estudiante debe proporcionar a la enferma de la escuela un formulario de *Consentimiento para administre medicamentos* firmado por el padre de familia o tutor legal y una *Receta de medicamentos de un proveedor con licencia.* Todos los medicamentos deben estar en el envase original y habar sido adquiridos en la farmacia.

Consentimiento de los padres de familia/tutor legal:

Doy permiso para que mi hijo, _____ Fecha:_____

Nombre del padre de familia/tutor

legal en tetra de imprenta: _____ Numero de telephone:_____

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: _____

5-14-2013