Licensed Prescriber Form
Beaver Area School District
School Year _____

Student's Name _____Grade_____

Medical Condition or Diagnosis: _____

Medication to be administered during school:_____

Route and dosage:_____

Time of administration:_____Medication allergies_____

Is this student capable of self-administration if the medication is an inhaler or an epi-pen?
_____yes _____no

Directions (if order is PRN, please be very specific):
_____
_____

In case of emergency, please observe student for:_____
_____

Restrictions/side effects:_____

_____ _____
(prescriber's printed name) **(phone number)**

_____ _____
(prescriber's signature) **(date)**

Parent/Guardian
I give permission for my child _____ to receive the above mentioned medication during the school day. I also give permission for the school nurse or school doctor to speak directly to the licensed prescriber if there are any specific questions or concerns. For self-administered medication ONLY: I relieve the Beaver Area School District and its employees of any responsibility for the benefits or consequences of the above listed medication that is physician prescribed and parent authorized. I further acknowledge that the school bears no responsibility for ensuring that the medication is taken. I am aware that any improper use of this medication will result in its immediate confiscation and loss of privilege to self-administer if the medication policy is violated.
_____ _____ _____ **(parent/guardian signature)** **(printed name)** **(date)**