Below is the Beaver Area School District Licensed Prescriber form. This form is to be utilized when a doctor/practitioner requests that your child must take a medication at school during school hours. Medications will be administered by the school nurse only.

A doctor/practitioner fills out the form and signs it, then the parent/guardian signs inside the box.

IMPORTANT--All medications whether they are prescription or over-the-counter MUST be delivered to the nurse by a responsible adult. Students may NOT have medications of any kind on themselves, in bookbags, lunch bags, purses, or in lockers. This is district policy and will be enforced. It is for the safety and well being of all students.

The only medications that students are permitted to carry are epi pens and asthma inhalers for life saving puproses. If your child will be carrying their own epi pen or inhaler, the licensed prescriber form below must <u>still</u> be filled out and on file with the nurse.

Please note that some physicians/practioners may charge a fee to fill out these forms so it is wise to ask the doctor to do this DURING a scheduled visit so that there is no charge.

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)**