

**DOWNINGTOWN AREA SCHOOL DISTRICT**  
**AUTHORIZATION FOR MEDICATION ADMINISTRATION (210-AG)**

Physician authorization and parent consent is required for the administration of prescription and over the counter medications in school.  
New medication orders are required annually and must be dated after June 30th.  
All medication **MUST** be delivered to the nurse's office by parent/guardian in a secure original pharmacy-labeled container.

**Student's Full Name:** \_\_\_\_\_ **Grade/Homeroom** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Allergies:** \_\_\_\_\_

\*\*\*\*\*

**Name of medication (Prescription/OTC):** \_\_\_\_\_

**Diagnosis/condition for which medication is prescribed:** \_\_\_\_\_

**Route of administration:** \_\_\_\_\_

**Dosage:** \_\_\_\_\_ **Time of administration:** \_\_\_\_\_

**Date medication administration begins:** \_\_\_\_\_ **Date medication administration ends:** \_\_\_\_\_

**In the event of a 2-hour delayed school opening, medication will be administered as indicated:**  
\_\_\_\_ @ original time noted above \_\_\_\_ @home only \_\_\_\_ @ the following time: \_\_\_\_\_

\_\_\_\_ Student is able to **self-carry** the emergency medications noted above--which are limited by law to include diabetes management medications/supplies, glucagon, asthma rescue medication, epinephrine auto injector--to/from/during school, on field trips, and at extra-curricular activities.

\_\_\_\_ Student is competent to **self-administer** the emergency medications noted above--which are limited by law to include diabetes management medication/testing supplies, asthma rescue inhaler, epinephrine auto injector--to/from/during school, on field trips, and at extra-curricular activities.

\_\_\_\_ Student is not permitted to self-carry and/or self administer any emergency medications.

\_\_\_\_\_  
**Physician's Signature**                      **Date**                      **Physician's Printed Name**

By signing below, parent requests the administration of the above-named medication as prescribed by the authorizing physician AND acknowledges their consent to permit their student to self-carry and/or self-administer diabetic management medications/supplies and/or emergency medications as determined by the physician's authorization stated above.

**\*\*Student's school-based competency to self-administer all referenced medications/supplies will be determined by the school nurse (No. 210.1-AG).\*\***

\_\_\_\_\_  
**Parent/Guardian Signature**                      **Date**                      **Parent/Guardian Printed Name**