ADMINISTRATION OF MEDICATION CONSENT FORM

Medications (both prescription and over the counter) may be administered at school by school personnel when necessary for school attendance. This completed form along with the medication and/or special equipment items are to be brought to the school by the parent/guardian.

As a parent, I understand my responsibilities are:

1. ***To provide the school with a supply of medication in the original sealed container. Prescribed medications need to be appropriately labeled by the pharmacy. (Parents may request that the pharmacist dispense two bottles of medication, one for home and one for school)***
2. ***To provide the school with the written doctor's instructions for prescription medication administration during school hours***
3. ***To inform the school of any medication and/or medical changes***

Medication means: "any prescription or over the counter medication. This includes, but is not limited to: vitamins and food supplements; eye, ear and nose drops; inhalants; medicated ointments or lotions; aspirins; cough drops; antacids."

Student: _____ Birthdate: _____ School Year: _____

Parent/Guardian Name: _____ Phone Number: _____

Doctor's Name: _____ Dr. Phone Number: _____

Doctor's Address: _____

I, _____ , _____ of
Parent/Guardian Name (printed) *Relationship*

_____ , do hereby request that the building administrator or his/her
Student's Name (printed)

designee, administer the (prescribed) medication listed below or procedure (listed below) as directed.

This also authorizes an exchange of information, as necessary, between the school and my child's health care provider.

Signature of Parent/Guardian: _____ Date: _____

Signature of Student if Adult: _____

For Prescribed Medications this section must be completed and signed by the Physician. For Over-the-Counter Medications this must be completed by the Parent/Guardian.

Reason / Condition for medication: _____

Name of Medication: _____

Form of Medication: ☐ tablet/capsule ☐ liquid ☐ inhaler ☐ injection ☐ nebulizer
☐ Other

Dosage: _____ Time ***during*** school _____

Restrictions / and or side effects: ☐ none anticipated ☐ Yes

Please describe _____

_____

Storage requirements: ☐ none ☐ refrigerate ☐ other

This student is both capable and responsible for self-administering this medication:

☐ No ☐ Yes

**Additional information: ☐ attached ☐ on back of form

_____ _____
Physician's name printed Physician's signature

Physicians's address: _____

Phone: _____ Fax: _____ Date: _____

This form will be renewed annually or whenever the prescription changes within the current school year.