

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. **Medication will not be administered at school until these criteria are met.**

As a parent, I understand my responsibilities are:

1. *To provide the school with a supply of medication in the original container 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 medication administration during school hours.*
3. *To inform the school of any medication and/or medical changes.*

Medication means: "Medication" shall include all medicines including those prescribed by a physician and any non-prescribed (over-the-counter) drugs, preparations, and/or remedies.

Student: _____ Birthdate: _____ School Year: _____

Parent/Guardian Name: _____ Phone Number: _____

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

Doctor's Address: _____

I, _____, _____ of
Name Relationship

_____, do hereby request that the building administrator or his/her designee, administer the (prescribed) medication listed below or procedure (listed below) as directed.

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

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: _____

Physician's name printed

Physician's signature

Physicians's address: _____

Phone: _____ Fax: _____ Date: _____

A copy of this form will be kept in the student's CA-60 and nurse's office and will be renewed annually or whenever the prescription changes within the current school year.