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 <u>two</u> 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.