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 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*.(per district policy 5330)

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.

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:________________________

To be completed by the Physician:

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:________________

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.