PARENT/GUARDIAN MEDICATION CONSENT FORM
Required for prescription & over-the-counter medications
to be administrated by school personnel
One form per medication

(Please print legibly)

Name of Student: _____

Date of Birth: _____ Grade: _____

Parent/Guardian: _____
(Please Print)

Day Phone: _____

Evening Phone: _____

I give permission to have the school personnel give the following medicine:

_____
(Name of medicine)

to _____
(Name of student)

I understand that I may pick up the medicine from the school at any time and that the medicine will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.

_____
Signature of Parent/Guardian Date

LICENSED PRESCRIBER MEDICATION ORDER FORM

Required for prescription medications to be administered by school personnel

One form per medication

Parents/guardians please note:

This form MUST be accompanied by the Parent/Guardian Medication Consent Form.

(Please print legibly)

Name of Student: _____

Licensed Prescriber: _____

Phone: _____

MEDICATION: _____

ROUTE: _____

DOSAGE: _____

FREQUENCY: _____

TIME(S) OF ADMINISTRATION: _____

Whenever possible, medication should be scheduled outside of school hours.

Specific instructions or information: _____

_____

_____

Side effects, contraindications, or possible adverse reactions: _____

_____

Date of Order: _____ Discontinuation date: _____

*Diagnosis: _____

*Any other medical conditions: _____

Signature of Licensed Prescriber: _____

Date: _____

*If not in violation of confidentiality.