



Meridian Medication Consent Form

Today's Date: _____ Medication Exp. Date: _____

Student's Name: _____

Grade: _____ Date of Birth _____

Medication: _____

Dosage: _____ Route: _____ Time: _____


Reason for medication: _____

- I have read the school policy for the administration of medication in the handbook
- I give my permission for the medication listed above to be administered while my child is at school by the school nurse/clinic aide or other designated staff
- I understand that all medications must be transported to and from school by an adult-
controlled substances will be counted by both the parent and nurse and signed in and out. This form is required for both prescription and over the counter medications
- Medications must be in an original bottle
- prescription medication must have a pharmacy prescription label
- Paperwork does not carry over to the next school year.
- Due to space limitations, I will try to bring medication in the smallest package/container

Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Signature: _____

Physician name _____ phone/fax _____

 Physician signature: _____

Disposition of medication: Picked up on: _____ Discarded on: _____

Witness: _____ Signature/Initial: _____ rev 8/2018