

Medication Administration Consent / Procedure Consent

If it is necessary for a student to receive medications at school, all appropriate portions of this form MUST be completed in order for the medication to be given at school. All medications must come in the original properly labeled container. One form for each medication is required.

Student Name: _____

Address: _____

Home Phone: _____ Cell/Work: _____

Physician: _____ Phone: _____

Emergency Contact: _____ Grade: _____

Food/Drug Allergies: _____ Diagnosis: _____

Medication / Procedure: _____

Dosage: _____ Frequency: _____ Route: _____

Date Ordered: _____ Duration of Order: _____

Parent Statement

It is the parent's responsibility for his/her child's medical needs. The school system shall not be held responsible; however, we will do everything possible to meet expressed requests. During school hours, the school nurse or individual designated by the nurse has my permission to administer the medication prescribed for: _____. Please understand that all prescription medications provided to the school must be labeled by the pharmacist and that any change requires a new form.

ASTHMA INHALERS AND EPI PENS ONLY:

- Yes This student and his/her parents/guardians have been instructed on self-administration and the student may carry an inhaler or Epi Pen at school.
- No

Parent/Guardian Signature _____ Date _____

*** Signature required from HEALTH CARE PROVIDER for daily or PRN ongoing prescription medications and treatments, not necessary for over the counter medications.**

Health Care Provider Signature _____ Date _____