

MEDICATION CONSENT FORM

Name of Student _____ Date of Birth _____

Grade _____ Teacher/Classroom # _____

****TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER****

REASON FOR MEDICATION _____

NAME OF MEDICATION _____

FORM OF MEDICATION/TREATMENT:

Tablet/capsule Liquid Inhaler Injection Nebulizer Other

INSTRUCTIONS (Schedule and dose to be given at school) _____

START Date form received Other Date: _____

STOP End of school year Other Date/duration _____

For episodic/emergency events only

RESTRICTIONS AND/OR IMPORTANT SIDE EFFECTS: NON ANTICIPATED

YES. PLEASE DESCRIBE _____

****SPECIAL STORAGE REQUIREMENTS:** NONE REFRIGERATE

OTHER _____

****PLEASE INDICATE IF YOU HAVE PROVIDED ADDITIONAL INFORMATION****

On the back side of this form As an attachment

Date _____ **Physician's Signature** _____

Physician's Name(please print):

Address:

Phone #:

****TO THE SCHOOL: Please report concerns about medications or disease to the above physician.****

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for (name of child) _____ to receive the above medication at school according to standard policy.

Date _____ Signature _____ Relationship _____