

CONSENT TO GIVE MEDICATION IN SCHOOL

In order for medication (prescription and non-prescription) to be given to your child during school, this form needs to be completed by both you and your child's doctor or clinic. Return the completed form to your child's school nurse.

Name of Child _____ Date of Birth _____ Grade _____ Rm. # _____

MEDICAL PROVIDER INFORMATION

Provider's name _____ Clinic/Practice name _____ Tel. _____ Fax _____
Diagnosis _____
Medication _____
Route of administration _____ Dosage _____
Frequency _____ Time(s) of administration _____
Date of order _____ Discontinuation date _____
Specific directions or information for medication _____
Any other medical condition(s)*/Allergies _____
Consent for self-administration (provided the primary care provider/parent determine it is safe and appropriate) Yes No
Other Information (Special side effects, contraindications or possible adverse reactions; other medications being taken, specific directions for storage):

 _____
Health Care Provider Signature Please Print Name Here Date

PARENT/GUARDIAN INFORMATION AND CONSENT


Parent/Guardian Name _____ Parent/Guardian Name _____
Tel # (H) _____ Tel # (H) _____
(C) _____ (C) _____
(W) _____ (W) _____
Email _____ Email _____

Other person(s) to be notified in case of medication emergency:


Name: _____ Relationship: _____ Telephone #: _____
Name: _____ Relationship: _____ Telephone #: _____

Please complete each item and initial.

I give permission to have the school nurse or school personnel designated by the school nurse administer this medication. _____ Yes _____ No (Please Initial)
I give permission to the school nurse to share information relevant to the prescribed medication administration as s/he determines appropriate for my child's health and safety. _____ Yes _____ No (Please Initial)
I give permission to the school nurse to photograph my child, to keep on file for identification purposes only. _____ Yes _____ No (Please Initial)
I understand I may retrieve the medication from the school at any time; however, the medication will be destroyed if it is not picked up within one week following termination of the order or by the last day of the school. _____ Yes _____ No (Please Initial)

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Parent/Guardian Signature Please Print Name Here Date

----- For Clinical / Office Use Only -----

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Nurse Signature Please Print Name Here Date