MEDICATION CONSENT FORM

SCHOOL: _____

Student:	DOB:	Date:
Grade/HR:		

I give my permission to the **School Health Counselor (SHC)/Licensed Practical Nurse (LPN)** to give my child the medication(s) **prescribed** by the Healthcare Provider; (in the event the School Health Counselor/LPN is not available to give the prescribed medication, the Community Health and Nursing Services Administrator or designee shall be notified in order to assign appropriate licensed personnel to administer). I also give permission to the licensed personnel to contact the prescribed Healthcare Provider for any medical concerns.

LICENSED PROVIDER'S ORDERS

It is necessary that the student named above receive the medication(s) listed below during school hours:

Diagnosis: _____ Re-evaluation Date: _____

Medication	Dose	Frequency	Time	Side Effects

Special Instructions/Self Administration: _____

_____Please initial if student may self-administer his/her medication.

_____ _____ _____

Parent/Guardian Print Parent/Guardian Signature Date

Physician's Signature_____ Date: _____

Clinic/Contact Info: _____

NOTE: MEDICATIONS SENT TO SCHOOL MUST BE IN ITS ORIGINAL CONTAINER LABELED FOR SCHOOL USE. MEDICATIONS SENT IN ANY OTHER CONTAINER OR WRAPPER WILL NOT BE ADMINISTERED AT SCHOOL.

Revised 8/15/16