Medication Consent Form

SY: _____ Date: _____ School: _____

Student: _____ DOB: _____ Grade: _____

I give my permission to the School Health Counselor (SHC) or designee to give my child the medication(s) **prescribed** by the doctor. (Because the School Health Counselor is not always available to give the prescribed medication, the school administrator or designee may occasionally be the administrator of the medication.) Also give permission to the SHC to contact the prescribed physician for any medical concerns.

Physician and Parent can authorize if the student is allowed to self-administer medication.

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Parent/Guardian Print Parent/Guardian Signature Contact Numbers

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THIS PART TO BE COMPLETED BY PHYSICIAN

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

Diagnosis: _____

Medication: _____
(Name/dose/frequency/time/side effects)

Medication: _____
(Name/dose/frequency/time/side effects)

Medication: _____
(Name/dose/frequency/time/side effects)

Special Instructions/Self Administration
_____

Re-evaluation date:_____

Date: _____ Physician/Clinic/Contact Info: _____

Note: Medication sent to school must be in original container labeled for school use. Medication sent in any other container of wrapper will not be administered at school.