Medication Consent Form

Student Name ____ School________________

008:.________________Grade:_ _ _ _ _ _ _ _ _ Primary Phone#:____________________________

Over the Counter Medications						Diagnosis/ Instructions/ Reason for Administration	School shall contact the clinic for any of the following symptoms:
Medication Name	Dosage	Route	Daily or As Needed	Time	Duration		
					From: To:		
					From: To:		
					From: To:		
					From: To:		

Prescription Medications (to be completed b • Practitioner)							School shall contact the clinic for any of the following symptoms:	Emergency Medication *Only* . Practitioner to initial box below if student is able to carry and self-administer.ie Inhaler, Eolneohrine.
Medication Name	Dosaoe	Route	Daily or As Needed	Time	Duration	Diagnosis/ Instructions/ Reason for Administration		
					From: To:			
					From: To:			
					From: To:			
					From: To:			

PRACTITIONER INFORMATION (needed for all prescription medication administered at school):

Practitioner Name: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Phone:____________________

Address: _

The above prescriptions medications will need to be administered at school:

Practitioner's Signature: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Date:_____________

Parent/Legal Guardian Consent (needed for all medication at school): Medication will be provided by parent and in **its original container or prescription labeled container.** I hereby give permission for school personnel to administer the above medication(s) to my child according to practitioner's and/or my instructions and authorize them to contact the practitioner if there is a question or concern. I further authorize the practitioner to render treatment to my child, as appropriate and necessary, arising out of administration of the medication. I further agree to hold the school and personnel giving medication harmless in any and all claims arising from the administration of this medication at school.

Signature of Parent/Legal Guardian: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Date:______________

In the event that your child will have some unused doses of medication left at the end of the year, please make arrangements to pick up these medications on the last day of school. Any medications left at school 2 weeks after the last day of the school year will be destroyed per school policy.

Signature of Parent/Legel Guardian:_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ **Date:**__________