



MEDICATION CONSENT FORM

Administration of Medication at School

Student Name _____ Date of Birth _____

Teacher _____ Grade _____

Medication _____

Diagnosis / Reason for giving: _____

Time to be given: _____ A. M. _____ P.M.

Prescription medication is to be furnished by the parent or guardian in the original container, with the pharmacy label which should include the medication name, dosage, and directions for the give the medical, the physician's name, the student's name, the pharmacy name and the prescription number.

Non-prescription medication [e.g. Tylenol, Motrin, and Allergy mediation] should be furnished in the original container. All medications will be kept in the nurse's office.

This consent form must by signed by the parent or guardian to authorize giving the medication during the school hours.

Special Instructions _____

Pharmacy Name _____ RX # _____

Prescribing Doctor _____

Parent/Guardian Signature

Date

Physician's Signature (Optional)

Date