

**MEDICATION CONSENT FORM**

Student's Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Age: \_\_\_\_\_

Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

**MEDICATION(S) TAKEN AT SCHOOL**

| <u>Medication</u> | <u>Strength</u> | <u>Number Taken</u> | <u>Time</u> |
|-------------------|-----------------|---------------------|-------------|
| _____             | _____           | _____               | _____       |
| _____             | _____           | _____               | _____       |
| _____             | _____           | _____               | _____       |
| _____             | _____           | _____               | _____       |

When it is necessary for medication to be given during school hours the following regulations must be followed:

1. Medication must be brought to school in the **original container with appropriate label intact**. Medication must be kept in a locked medicine area. **If medication if not properly labeled it will not be given.**
2. Parent/ guardian and physician must sign this form granting permission for the nurse or nurse designee to administer medication.

The nurse or nurse designee has my permission to administer the above medication(s) as prescribed by Dr. \_\_\_\_\_ . I give my permission to the School Nurse to contact the Dr. if necessary regarding the medication(s).

Parent/ Guardian Signature: \_\_\_\_\_

Physician Signature: \_\_\_\_\_