Immaculate Conception School

1 Washington Street, Newburyport, MA 01950 ~ 978 • 465 • 7780 ~ www.icsnewburyport.com

Medication Consent Form for School

Name of Student_____ **D.O.B.**_____ **Age**____

Grade_____ Teacher_____ Date of Medication Order_____

Name of Licensed Prescriber_____

Address of prescriber_____

Business telephone number_____

Diagnosis or Medical Condition of Student _____

Food or Drug Allergies_____

Medication Name_____ Medication Dose_____

Medication Route_____ Medication Frequency_____

Time to be given or specify if prn (as needed)_____

Specific directions for administration of medication:

Side effects or contraindications:

The nurse at Immaculate Conception School has my permission to administer the above medication(s) as prescribed by _____.

Parent/Guardian Name_____ Parent/Guardian Signature_____

Date_____

Physician/Licensed Prescriber's Signature _____ Date _____