

Medication Administration Consent Form

Note to parent or guardian

1. Medication Administration Consent Form must be completed and signed by parent/guardian and the PCP.
2. It is the parents responsibility to inform the school nurse of field trips and extracurricular activities so that proper accommodations can be made for dispensing your child's medications. Only authorized personnel will be allowed to dispense medication.
3. I, parent /guardian, give permission to the school nurse or other designated staff to administer medication(s) to your child during the school day. The medication policy of the district will be followed.
4. Medication must be in the original container from the pharmacy. Controlled medications will be counted with parents/guardians and school nurse when medications are brought to the school.
5. I will not hold school staff responsible for any undesired reaction, which may occur, from this medication.

Parent/Guardian initials_____

TO BE COMPLETED BY PARENTS/GUARDIAN:

Name of student:_____Grade:_____

Date of Birth:_____PCP:_____PCP Phone:_____

Medical Condition:_____

I give permission for _____ (PCP) to release specific healthcare information regarding my child to the school nurse.

Parent/ Guardian Signature:_____Date:_____

Emergency Contact:_____Phone:_____

TO BE COMPLETED BY Physician (PCP):

Medical Diagnosis:_____

Medication(s) to be taken at school:_____

Dosage:_____Time:_____

Specific Instructions:_____

Physician Signature:_____Date:_____