CONSENT FOR ADMINISTERING MEDICATION AT SCHOOL

☐ Short-Term Prescription ☐ Inhaler - not self carrying ☐ Over-the-Counter Medication

Student Name:_____ Date of Birth:___/___/_____ Grade:_____

Student ID#:_____ School:_____

Teacher (Elementary Only):_____ Room#:_____

Medication:_____

Reason for Medication:_____

Dosage:_____

Time of Day to be administered:_____

Duration:_____ to _____

Physician Name:_____

Physician Phone:_____ Physician Fax:_____

PARENT/GUARDIAN CONSENT

I DO ☐ I DO NOT ☐ specifically consent to transmission of my child's medical records via facsimile (fax).

I give my consent for the school designated personnel to administer the listed medication.
All medication must be hand delivered by an adult and in it's the original container.

Note: Physician's permission is required in order for medication to be administered for an extended period or quantity other than listed on the label.

I authorize the physician to speak with the registered nurse regarding my child and this medication.

_____	_____	_____
Parent/Guardian Signature	Parent/Guardian Phone #	Date

Nurse Notes: _____

_____

_____

_____

Date	Amount	Signature RN/Other

Revised 4/14