

Consent form for administration of medication during the school day

Before any medication is administered by school personnel this form must be completed and on file in the school office. Renew each year.

Pupil's Name _____ Birthdate _____ Grade _____
Home Address _____ School _____ School Year _____

Physician's Order (Medical Provider fills in)

I have prescribed the following medication for this child and request school personnel to administer the medication during the school day.

MEDICATION _____

DOSAGE and TIME _____

SPECIFIC INSTRUCTIONS _____

POSSIBLE SIDE EFFECTS _____

INHALERS, INSULIN, EPI-PENS: Has the child received instructions and permission for self-administration? YES NO

Physician's Signature: _____ Date: _____

Print Name: _____

Office Address _____ Phone: _____

Parent/Guardian Authorization: FOR PRESCRIPTION MEDICATION (Doctor's note required)

- I request the medication(s) listed by my medical provider on this sheet, be given during the school day.
I give permission for the school nurse/designee and medical provider to exchange information regarding this medication and the diagnosis for which it is prescribed.
I release school personnel from any liability in relation to the administration of this medication at school. (Administration of this medication will not necessarily be done by the school nurse).
I will provide this medication in the original, properly labeled pharmacy bottle and transport it to the school.
I will provide a medication discontinuation order from the physician if the medication is stopped.
I understand that this form does not apply to after school activities or summer school.

By signing below, I agree to all of the above listed items.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Authorization: FOR NON-PRESCRIPTION MEDICATION

MEDICATION _____ PURPOSE FOR MEDICATION _____

DOSAGE and TIME _____

- I release school personnel from any liability in relation to the administration of this medication at school. (Administration of this medication will not necessarily be done by the school nurse).
I will provide medication in the original bottle with child's name on it and transport it to the school.
I understand that this form does not apply to after school activities or summer school.

By signing below, I agree to all of the above listed items.

Parent/Guardian Signature _____ Date _____