

## Consent to Give Medication in School

In order for medication to be given to your child during school, this form needs to be completed by both you and your child's doctor or clinic. Return the completed form to you child's school nurse.

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

### Medical Provider Information

Diagnosis\* \_\_\_\_\_

Medication \_\_\_\_\_

Route of Administration \_\_\_\_\_ Dosage \_\_\_\_\_

Frequency \_\_\_\_\_ Times (s) of Administration \_\_\_\_\_

Date of Order \_\_\_\_\_ Discontinuation Date \_\_\_\_\_

Specific directions or information for medication: \_\_\_\_\_

Any other medical condition (s)\* /Allergies \_\_\_\_\_

Date for next scheduled visit \_\_\_\_\_

Consent for self-administration (provided the school nurse determine it safe and appropriate): Yes c    No c

X \_\_\_\_\_

Signature of Licensed Prescriber                      Please Print Name Here                      Business Telephone Number

Optional Information: (Special side effects, contraindications, or possible adverse reactions; other medications being taken)

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### Parent/Guardian Information

Parent/Guardian  
Name \_\_\_\_\_

Tel # (H) \_\_\_\_\_

(W) \_\_\_\_\_

Parent/Guardian  
Name \_\_\_\_\_

Tel # (H) \_\_\_\_\_

(W) \_\_\_\_\_

Other person(s) to be notified in case of medication emergency:

Name: \_\_\_\_\_

Telephone number: \_\_\_\_\_

Name: \_\_\_\_\_

Telephone number: \_\_\_\_\_

### **Parent/Guardian CONSENT**

I give permission to have the school nurse or school personnel designated by the school nurse administer this medication:  
Yes \_\_\_\_\_ No \_\_\_\_\_ (Please Initial)

I give permission to the school nurse to share information relevant to the prescribed medication administration as s/he determines appropriate for my child's health and safety.  
Yes \_\_\_\_\_ No \_\_\_\_\_ (Please Initial)

I give permission to the school nurse to photograph my child, to keep on file for identification purposes only.  
Yes \_\_\_\_\_ No \_\_\_\_\_ (Please Initial)

I understand I may retrieve the medication from the school at any time; however, the medication will be destroyed if it is not picked up within one week following termination of the order or by the last day of school.

\_\_\_\_\_  
Parent/guardian Signature

\_\_\_\_\_  
Date