Parent / Guardian Medication Consent Form

(Please type or print)

Name of School____

Address of School____

____

Telephone # of School____

Full Name of Child to be Medicated______________________________

Name of Drug and dosage______________________________________

Hour(s) Medication is to be given____________________# of Days____________________

Name of Physician Prescribing Medication________________________

Physician's Phone Number_____________________________________

I hereby give permission to the Health Room / Office Personnel to give the medication(s) to my child according to the directions stated above and further authorize them to contact the child's physician. I agree to hold the above-named school, its employees, and agents who are acting within the scope of their duties, harmless in any and all claims arising from the administration of this medication at school.

I agree to notify the school, in writing, at the termination of this request or when any change in the above order is necessary.

____

Signature of Parent / Legal Guardian date

____

Address

____

Home Phone # Work Phone #

____

Cell Phone

Please return this form completed on the FRONT and BACK, along with the medication(s), to the school office.

continued...

PHYSICIAN REQUEST AND AUTHORIZATION

Name of School: ____________________

Address of School: ____________________

Tele. # of School: ____________________

Name of Student: ____________________ Address: ____________________

Home Phone #: ______________ Student Age: ____________ Student Grade: ____________

Diagnosis: ____________________

PHYSICIAN MEDICATION ORDERS:

Daily Medications

Medicine	Route	Dose	Frequency	Duration	Direct contact shall be made with me should the student receiving the medication develop any of the following condition or reactions to the medications
				From: To:	
				From: To:	
				From: To:	

PRN Medications (as needed)

Medicine	Route	Dose	Frequency	Duration	Conditions Under Which Medication Should Be Given	Direct Contact Shall Be Made With Me Should The Student Receiving The Medication Develop Any Of The Following Conditions Or Reactions To The Medication
				From: To:		
				From: To:		
				From: To:		

The information on this form constitute my physician medication orders for the subject student. I agree to retain the power to direct, supervise, decide, inspect, and oversee the administration of such medication(s). Direct contact shall be made with me at any time should you have any questions.

Hospital/Clinic/Office ____________________ Address: ____________________

Physician's Signature ____________________ Phone #: ____________________

Date: ____________________