Medication Consent

If it becomes necessary for a student to take medication or receive treatment during the school day, the parent or guardian must complete this request form and submit it to the school nurse. If the medication or treatment is physician prescribed, the parent or guardian must provide a written prescription from the child's physician or the current pharmacy label attached to the medication.

All other over-the-counter medication must be in the original container labeled with the student's name and date of birth. Label instructions will be followed for all over-the-counter medicine unless otherwise prescribed by a physician.

Parent's or Guardian's Authorization

I request that the medication described below be administered to my child at the times specified during the school day. I will give the nurse the medication in its original container or current prescription bottle.

I understand that a separate form must be completed for each medication. This request is in effect for one school year and must be renewed annually or whenever there is a change in medication.

I understand that this medication will be administered to my child only by authorized staff members and will be kept in a secure location within the school nurse clinic.

I understand that a parent or guardian will transport all medication to school.

I understand that a parent or guardian will transport all medication from school unless permission is granted below for the student to carry medication home at the end of the school day (this does not include controlled substances which must be picked up by a parent/guardian). Medications must be picked up by the last day of school or they will be discarded.

☐ I give my permission for my child to bring home any unused medication at the end of the school day.

____
Student's Name (Please Print)

Student's Date of Birth: _____/______/_______
Month Day Year

____
Name of Medication

Prescribed ☐ Over-the-Counter ☐

____
Days Medication is to be given

Time(s) to administer _______a.m. _______p.m.

____
Amount of Medication to be given

____
Purpose of Medication

____
Signature of Parent or Guardian

____
Date

____
Printed Name

____
Primary Phone #