School Medication Consent

Student Name: _____ **Grade:** ____ **Birth Date**: _____
Parent/Guardian Name: _____
Primary Phone: _____ **Cell**: _____ **Work**: _____
Diagnosis(es): _____

Prescription medication orders must be completed by practitioner ONLY

Medication Name: _____
Administration Instructions(Dose/Route/Time/s): _____
_____
Effective Date: School Year 20___ - ___ (including summer school) **OR** From _____ To _____

Medication Name: _____
Administration Instructions(Dose/Route/Time/s): _____
_____
Effective Date: School Year 20___ - ___ (including summer school) **OR** From _____ To _____

Medication Name: _____
A**dministration Instructions(Dose/Route/Time/s)**:_____
_____
Effective Date: School Year 20___ - ___ (including summer school) **OR** From _____ To _____

Comments: _____
_____

PARENT/GUARDIAN I *hereby give permission to staff designated by the school principal or nurse to give the above medication to my student according to the instructions stated above and authorize them to contact the practitioner, if necessary.*

Parent/Guardian Signature: _____ Date: _____

PRACTITIONER *practitioner signature directs the above medication administration and indicates willingness to communicate with school staff regarding this medication.*

Practitioner Signature: _____ Date: _____

Practitioner Name, Address, Phone
_____
_____
_____