SCHOOL MEDICATION ADMINISTRATION PROCEDURE CONSENT

The administration of medication at school is discouraged unless medically necessary. School personnel have been requested to administer the medications listed below during the program day. As parents/guardians/ primary caregivers of the individual and primary physician of the individual, please review the medication procedure, complete, sign and return this form authorizing its use.

Child's Name ______________________ Date of Birth ______________________

Address ______________________ Grade ______________________

______________________ Building/Program ______________________

PLEASE TYPE OR PRINT CLEARLY

Medication Name ____

Route ______________ Dosage ______________ Time(s) ______________

Special Instructions for administration, including sterile conditions and storage:

____

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Severe adverse reactions that should be reported to the physician: ______________________

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☐ Student has been instructed by prescriber in self administration of asthma inhaler or epipen and may self-carry for self-administration.

Date to begin administration of medication at school: ______________________

Date to cease administration of medication at school: ______________________

______________________ ______________________ ______________

Physician's Signature Physician's Printed Name Date

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Physician's telephone number

For Parent:

I have reviewed the above information and authorize medication administration as stated. I agree to do the following:

1) Deliver or send any needed medications in a pharmacy container labeled with the name, medication, route, dosage, and time to be taken.
2) Notify School Staff in writing with the physician's signature that the above medication has had a change (i.e., route, dosage, time) or has been discontinued.

______________________________ ______________________

Parent/Guardian/Primary Caregiver Signature Date