Authorization/Parental Consent for Administering Medication

PRESCRIPTION MEDICATION

Student Name_____ DOB_____
(If student is unable to state full name and date of birth please send a clear picture of the student's face to school so that the child may be identified correctly to ensure safety.)

Allergies to medications: _____

Parental Consent:

I am the parent or guardian of _____. I give permission for the school personnel to administer the following medication at school. I will provide the medication in the original labeled bottle.

_____ _____ _____
Parent/Guardian Signature Daytime Phone Number Date

Medication and Dosage _____

Time to be administered _____

Diagnosis for Medication_____

Medication Discontinue Date_____

Physician Signature _____ Date _____

Physician Phone Number _____

For Students with Asthma or Diabetes only:

This student is both capable and responsible for self-administering:
_____NO _____ YES

This student may carry this medication with him/her: _____NO_____ YES

A FORM IS REQUIRED FOR EACH MEDICATION TO BE TAKEN AND MUST BE RENEWED AT THE BEGINNING OF EACH SCHOOL YEAR.