CONSENT FOR ADMINISTRATION OF MEDICATION

Effort should be made to give medication at home and avoid school hours for administration

Parent completes this section

Name of Student_____ **Grade**_____ **Name of Medication**_____

I request that my child (named above) be given the medication (named above) as prescribed by a physician. I understand that I must provide this medication in a properly labeled pharmacy bottle. I further understand that a designated staff person will administer the medication. I release school personnel from liability in relation to the administration of this medication.

Signature of Parent/Guardian_____ **Date**_____ **Telephone #** (_____)_____

Physician completes this section/Not needed if non-prescription

The student named above is my patient. I request that the medication named above and provided by the Parent/Guardian be given to this student as directed on the prescription label.

If noticed, report these side effects to my office:_____

This Student may may not self-administer the mediation (example: inhaler)

Signature of Physician_____ **Date**_____ **Telephone #** (_____)_____

Staff Administering Medication completes this section

Student Name_____	Grade _____												
Medication & Reason for taking	Dose Given	Date, Time Given & By Whom (initial block)											

Side Effect to watch for

Parent Permission obtained on (date)_____Permission received by_____

Name of Parent: _____

signature of staff member authorized to give Medication_____