**ADMINISTRATION OF MEDICATION CONSENT FORM**

Medications (both prescription and over the counter) may be administered at school by school personnel **when necessary** for school attendance. This **completed** form along with the medication and/or special equipment items are to be brought to the school by the parent/guardian. **Medication will not be administered at school until these criteria are met**.

***As a parent, I understand my responsibilities are:***

1. ***To provide the school with a supply of medication in the original container appropriately labeled by the pharmacy. (Parents may request that the pharmacist dispense two bottles of medication, one for home and one for school.)***
2. ***To provide the school with the written doctor’s instructions for medication administration during school hours.***
3. ***To inform the school of any medication and/or medical changes.***

***Medication*** means: “*Medication" shall include all medicines including those prescribed by a physician and any non-prescribed (over-the-counter) drugs, preparations, and/or remedies*.

Student:       Birthdate:       School Year:

Parent/Guardian Name:       Phone Number:

Doctor’s Name:       Dr. Phone Number:

Doctor’s Address:

I,       ,       of

*Relationship*

*Name*

      , do hereby request that the building administrator or his/her designee, administer the (prescribed) medication listed below or procedure (listed below) as directed.

Reason / Condition for medication:

Name of Medication:

Form of Medication: [ ]  tablet/capsule [ ]  liquid [ ]  inhaler [ ]  injection [ ]  nebulizer

 [ ]  Other

 Dosage:       Time ***during*** school

 Restrictions / and or side effects: [ ]  none anticipated [ ]  yes

 Please describe

 Storage requirements: [ ]  none [ ]  refrigerate [ ]  other

 This student is both capable and responsible for self-administering this medication:

 [ ]  No [ ]  Yes

\*\*Additional information: [ ]  attached [ ]  on back of form

***This also authorizes an exchange of information, as necessary, between the school and my child’s health care provider****.*

Signature of Parent/Guardian:       Date:

Signature of Student if Adult:

Physician’s signature

Physician’s name printed

Physicians’s address:

Phone:       Fax:       Date:

A copy of this form will be kept in the student’s CA-60 and nurse’s office and will be renewed annually or whenever the prescription changes within the current school year.