

## 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  
Name Relationship

\_\_\_\_\_, 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 name printed

\_\_\_\_\_  
Physician's signature

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.