MEDICATION CONSENT FORM

Student_____Grade_____Homeroom_____

I understand that special permission is required for the use of ANY medication during school hours and that medication may only be given by the School Nurse-Teacher. I request that my child be given the medication described below or be permitted to self-carry/self-medicate as authorized by me and my physician.

_____ _____ _____

(Parent/Guardian Signature) (Relationship) (Date)

This Section to be Completed By Physician

Diagnosis/Reason for Medication_____
Name of Medication_____
Dose_____ Route_____ Time to be Given_____
If medicine is to be given PRN, please describe indications:
_____
_____

Start: ☐ Date form received Other date:_____
Stop: ☐ End of school year Other date: _____

Restrictions/Important side effects: _____

SPECIAL REQUIREMENTS:
For Inhalers and Epinephrine auto injectors:

- ☐ Student may self-carry medication
- ☐ Student may self-administer medication

For Field Trips:

- ☐ This medication may be omitted on field trip
- ☐ This student is capable to self-carry/self-administer this medication
  (**NOTE:** Please refer to procedure for students to self-carry/self-administer medication on field trips)

Date: _____ Physician's Signature: _____

Physician's Name: _____
Address: _____
_____
Phone: _____