

## CONSENT TO GIVE MEDICATION IN SCHOOL

In order for medication (prescription and non-prescription) to be given to your child during school, this form needs to be completed by both you and your child's doctor or clinic. Return the completed form to your child's school nurse.

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_ Rm. # \_\_\_\_\_

### MEDICAL PROVIDER INFORMATION

Provider's name \_\_\_\_\_ Clinic/Practice name \_\_\_\_\_ Tel. \_\_\_\_\_ Fax \_\_\_\_\_  
Diagnosis \_\_\_\_\_  
Medication \_\_\_\_\_  
Route of administration \_\_\_\_\_ Dosage \_\_\_\_\_  
Frequency \_\_\_\_\_ Time(s) of administration \_\_\_\_\_  
Date of order \_\_\_\_\_ Discontinuation date \_\_\_\_\_  
Specific directions or information for medication \_\_\_\_\_  
Any other medical condition(s)\*/Allergies \_\_\_\_\_  
Consent for self-administration (provided the primary care provider/parent determine it is safe and appropriate)  Yes  No  
Other Information (Special side effects, contraindications or possible adverse reactions; other medications being taken, specific directions for storage):  
\_\_\_\_\_

 \_\_\_\_\_  
Health Care Provider Signature Please Print Name Here Date

### PARENT/GUARDIAN INFORMATION AND CONSENT


Parent/Guardian Name \_\_\_\_\_ Parent/Guardian Name \_\_\_\_\_  
Tel # (H) \_\_\_\_\_ Tel # (H) \_\_\_\_\_  
(C) \_\_\_\_\_ (C) \_\_\_\_\_  
(W) \_\_\_\_\_ (W) \_\_\_\_\_  
Email \_\_\_\_\_ Email \_\_\_\_\_

Other person(s) to be notified in case of medication emergency:


Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Telephone #: \_\_\_\_\_

#### Please complete each item and initial.

I give permission to have the school nurse or school personnel designated by the school nurse administer this medication. \_\_\_\_\_ Yes \_\_\_\_\_ No (Please Initial)  
I give permission to the school nurse to share information relevant to the prescribed medication administration as s/he determines appropriate for my child's health and safety. \_\_\_\_\_ Yes \_\_\_\_\_ No (Please Initial)  
I give permission to the school nurse to photograph my child, to keep on file for identification purposes only. \_\_\_\_\_ Yes \_\_\_\_\_ No (Please Initial)  
I understand I may retrieve the medication from the school at any time; however, the medication will be destroyed if it is not picked up within one week following termination of the order or by the last day of the school. \_\_\_\_\_ Yes \_\_\_\_\_ No (Please Initial)

 \_\_\_\_\_  
Parent/Guardian Signature Please Print Name Here Date

----- For Clinical / Office Use Only -----

 \_\_\_\_\_  
Nurse Signature Please Print Name Here Date