PARENT CONSENT FORM

I authorize the Principal/designee of _____ School to administer

_____ to my child _____,
(name of Rx and dosage) (name)

Grade/Teacher _____ at the time indicated below: (check which)

1) _____ Medication at _____o'clock.

2) _____ As necessary to control asthma or wheezing for which this medication was specifically prescribed, but no more often than every four hours.

3) _____ As necessary for _____.

The medication shall be provided in a bottle showing the name of the pharmacy, student's name, physician's name and the dosage of the medication to be given. **I understand that the first dose of any medication must be given at home.**

I absolve the school personnel of all responsibility for any unforeseen development or reaction attributable to the administration of the above named medication. **It is the responsibility of the child to come to the office to take his/her medication.**

This authorization will terminate completely on _____.
(specific date)

_____ _____
(date of authorization) (parent/guardian signature)

Physician signature/instructions for dose(s) other than noontime _____

_____

DATE/TIME/INITIAL	DATE/TIME/INITIAL	DATE/TIME/INITIAL

_____ _____ _____ _____
Signature Initials Signature Initials

_____ _____ _____ _____
Signature Initials Signature Initials

NAME OF CHILD ______________________________ **Rx** ________________________ **DOSAGE** ___________________

DATE/TIME/INITIAL	DATE/TIME/INITIAL	DATE/TIME/INITIAL