CONSENT FOR MEDICATION ADMINISTRATION

STUDENT _____

GRADE/TEACHER _____

I authorize the Principal/designee of _____ School to administer the following to my child:

MEDICATION: _____

DOSE: _____

TIME: (check and fill in correct time/reason for medication)

1) _____Medication at _____o'clock.

2) _____As needed to control asthma or wheezing but no more often than every 4 hours.

3) _____As necessary for _____

- Prescribed medication will be provided in the original container stating the name of the medication, student's name, the name of the pharmacy, physician's name and the dose to be given.
- Over the counter medications will be in the original store container and in an age appropriate form and dose.
- Consents for cough medications will be good for a maximum of 2 weeks.
- The first dose of any medication must be given by parent/guardian.
- Parent/guardian is responsible to pick up medications from school.

I absolve the school personnel of all responsibility for any unforeseen development/reaction due 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.

Authorization start date _____ Authorization end date _____

Parent/guardian signature _____

_____

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

_____ Signature _____ Initials _____ Signature _____ Initials

_____ Signature _____ Initials _____ Signature _____ Initials

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NAME OF CHILD ______________________________ Rx ________________________ DOSAGE ____________________

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