MEDICATION CONSENT FORM

The following information is necessary for any student to use prescribed or over-the-counter medications or treatment in school. ALL spaces MUST be completed.

Student's Name: _____ Grade: _____

Student's Known Allergies: _____

Prescription Medication: _____

Over-The- Counter medication: _____

Dosage: _____

Reason for use: _____

Directions: _____

I, _____ authorize the school Nurse to share the above information with the staff member (s) who would benefit knowing to insure optimal care for your child and his or her health needs.

I, _____ authorize the school Nurse or other designated school employee to administer the above named medication to my child during school hours and will:

1. **I will assume responsibility for a safe delivery of the medication or treatment.**
2. **I will notify the school immediately if there are any changes in the use of the medication or treatment.**
3. **Our physician has instructed that this medication or treatment should be administered in the above designated dosage.**

Parent/Guardian Signature: _____ Date: _____

Phone number for an emergency: _____