YES Prep Public Schools

Medication/Treatment Administration Consent Form

Name of Child: _____

Date of Birth:_____

Grade: _____Campus:_____

Diagnosis: _____

In order to keep my child in optimal health and to help maintain his/her school performance, it is necessary that he/she receive the above mentioned medication during school hours. I hereby release YES Prep Public Schools and any of its employees from liability in carrying out this treatment. Should my child manifest any of the following symptoms_____reaction caused by the above procedure, please contact_____at _(___)_____and/or my child's physician_____at_(___)_____immediately. I agree to cooperate with school personnel to the best of my ability in following the treatment or care that has been recommended by the physician for my child. It is my understanding that school personnel cannot perform this procedure unless treatment is during school hours and is ordered in writing by a physician.

Name of medication:_____ Dosage:_____

Dr./Pharmacist Instructions for Medication: _____
_____

No injection will be given except in extreme emergency, such as allergic reaction.

Medication/Treatment		Administered by:	Medication/Treatment		Administered by:
DATE/TIME		SIGNATURE	DATE/TIME		SIGNATURE

Parent/Guardian Signature: _____

Witness:_____ Date:_____