



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

Parent/Guardian Signature: _____

Witness: Amelia Khan Date: _____