Prescription Medication Consent Form

Medication must be in its current prescription vial. Medication will only be dispensed according to the directions listed on the prescription vial. Directions must be specific. A parent or guardian must bring medication to the Health Room. **MEDICATION MUST NOT BE SENT TO SCHOOL THROUGH THE STUDENT.** Students are responsible for coming to the Health Room to take their medication at the given time.

Student Name____**DOB**_______________ **Grade**_______

Reason for Medication____

Date Medication Received	Name of Medication/Dose/Time	# of Pills/ oz/ml or Inhaler	Parent Signature	School Representative Signature

Parent Name (print)______________________________________Contact Phone # _____________________

Doctor's Name____ Phone#_________________________

I, the parent/guardian, certify that at least two doses of the medication listed above have been given previously and **NO** adverse reactions were experienced. Therefore, I give permission for the School Nurse or appointed personnel to administer the above listed medication to my child. The School Nurse also has permission to contact the prescribing physician for information related to this condition or medication. A photo of my child may be placed on this form for identification purposes.

____ ______________________________

(Parent/Guardian Signature) **(Date)**

*A separate form must be completed for each medication to be administered