

**TYRONE AREA SCHOOL DISTRICT
MEDICATION CONSENT FORM**

**THE FOLLOWING INFORMATION MUST BE PROVIDED IN ORDER FOR ANY
MEDICATION, PRESCRIPTION OR OVER-THE-COUNTER, TO BE ADMINISTERED.**

NAME OF STUDENT: _____

DIAGNOSIS: _____

NAME OF MEDICATION: _____

DOSAGE: _____ TIME: _____

SPECIAL INSTRUCTION: _____

POSSIBLE SIDE EFFECTS: _____

IS STUDENT CAPABLE OF SELF ADMINISTRATION: _____

STARTING DATE: _____ ENDING DATE: _____

PHYSICIAN'S SIGNATURE

DATE

PHYSICIAN'S TELEPHONE #

PHYSICIAN'S FAX #

**ATTENTION: ALL MEDICATION MUST BE SENT TO SCHOOL IN THE ORIGINAL
PHARMACY CONTAINER. OVER-THE-COUNTER MEDICATION MUST BE PROVIDED IN
ITS ORIGINAL CONTAINER. MEDICATION CANNOT BE DISPENSED FROM UNLABELED
CONTAINERS.**

PARENTAL PERMISSION: I hereby give my permission for a school nurse or other designated person of the Tyrone Area School District to administer medication to my child or to assist in self-administration as prescribed by his/her physician and as outlined on this form. I agree to release the Tyrone Area School District personnel of all responsibility in terms of my child taking this prescription/over-the-counter medication during the school day.

PARENTAL SIGNATURE

DATE

I authorize the school nurse to provide student progress reports related to this medication to the prescribing physician.

PARENTAL SIGNATURE

TELEPHONE #

DATE