MEDICATION CONSENT

(Daily or as needed basis)

In order for a prescribed medication to be given at the Gordon School, this form must be signed by the parent/guardian and completed by the student's physician.

I understand that the medication(s) will need to be in the original prescription container. I authorize that my child be given the following medication at school as directed by the physician.

_____ _____

Signature of Parent/Guardian Date

PHYSICIAN'S ORDERS

I give permission for the following medication to be administered to the student named below, during the 2024-2025 school year.

Student Name: _____ **Date of birth** _____

Name of medication: _____

Dosage of medication: _____

Route of administration: _____

Time to be given: _____

Reason for medication: _____

Possible side effects: _____

Duration to be given: _____

____ This order is also applicable to any school sponsored field trips.

_____ _____

Physician signature Date