J.O. Combs Unified School District - Health Services Department

PARENT/GUARDIAN CONSENT FOR GIVING OVER THE COUNTER MEDICATION AND/OR SHORT TERM ANTIBIOTICS (10 DAYS OR LESS PRESCRIBED BY A DOCTOR) AT SCHOOL

I give my consent for the school Nurse, Health Assistant, or designated personnel to administer the following medication. All medication will be furnished by me in the original container and not have expired. Doctor's permission is needed for any OTC medication given more than 3 days in a row. Short term antibiotics must have pharmacy label clearly legible with all pertinent information included.

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Student Age Grade

____

Teacher Room

____

Medication Dosage Route

____

Time of day to be given Duration

____

Doctor's Name Phone

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Reason for Medication

I authorize the physician to speak with the RN/District Nurse regarding my child and this medication.

Do____ Do not____ specifically consent to transmission of my child's medical records via fax

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Signature of parent or guardian Date

Comments by the Nurse/HA____