

### School Medication Consent

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Parent/Guardian Name: \_\_\_\_\_  
Primary Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_  
Diagnosis(es): \_\_\_\_\_

**Prescription medication orders must be completed by practitioner ONLY**

Medication Name: _____ Administration Instructions(Dose/Route/Time/s): _____ Effective Date: School Year 20__ - __ (including summer school) <b>OR</b> From _____ To_____
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Medication Name: _____ Administration Instructions(Dose/Route/Time/s): _____ Effective Date: School Year 20__ - __ (including summer school) <b>OR</b> From _____ To_____
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Medication Name: _____ Administration Instructions(Dose/Route/Time/s): _____ Effective Date: School Year 20__ - __ (including summer school) <b>OR</b> From _____ To_____
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Comments: \_\_\_\_\_  
\_\_\_\_\_

**PARENT/GUARDIAN** I hereby give permission to staff designated by the school principal or nurse to give the above medication to my student according to the instructions stated above and authorize them to contact the practitioner, if necessary.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PRACTITIONER** signature directs the above medication administration and indicates willingness to communicate with school staff regarding this medication.

Practitioner Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Practitioner Name, Address, Phone  
\_\_\_\_\_  
\_\_\_\_\_