OKEMOS PUBLIC SCHOOLS

Student Health and Safety

Consent for District Administered Medication Form

Student Information

Student's Name: _____

Date of Birth: _____ Grade: _____

Healthcare Provider Information

Name/Title: _____

Address: _____

Telephone: _____ Fax: _____

Provider Signature: _____ Date: _____

Medication Information

This section must be completed by the Student's healthcare provider.

Medication Name: _____ Dose: _____

Administration Method: _____ Administration Time/frequency: _____

If "as needed," under what conditions is the medication to be administered:

_____

Relevant side effects: _____

_____

Parent/Guardian Consent

I, _____ , authorize school staff to administer medication accordance with this form and applicable Policies. I acknowledge that Board Policy requires that I immediately inform the District of any changes to the healthcare provider's medication instructions.

Parent's/Guardian's Signature: _____ Date: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

(Please circle which phone number you would like District staff to call first.)