

## SCHOOL MEDICATION CONSENT FORM

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ DOB: \_\_\_\_\_  
Parent/Guardian: \_\_\_\_\_  
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 _____

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

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

Comments: \_\_\_\_\_  
\_\_\_\_\_

**PARENT/GUARDIAN SIGNATURE** 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** 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  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_