Medication Order and Parent/Guardian Consent

Name of Student:___________________________ Date of Birth: __________Grade______

Name of Parent/Guardian:____

Student Address:____

Home Phone:______________Work Phone:______________Cell Phone: ____________

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Name of Prescriber: ___________________________________Phone: _______________

Address:____

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Medication:______________________________Dose:_________________Route:______

Time given at school:________________Start date:__________ End date:____________

Diagnosis: ________________________________Allergies: _________________________

Other medications taken by student: ____

- I give permission to the nurse at school to administer this student the medication on this order.
- I give permission for the nurse at school to share with appropriate school staff information relative to the prescribed medication administration as deemed necessary Yes_____No_____
- I give permission for this student to self-administer medication if the nurse at school determines it is safe and appropriate (inhalers, Epipen, insulin only). Yes________No________
- I give designated school personnel permission to administer this medication on a field trip during this school year (scheduled medications, inhalers and EpiPen only). Yes_____ No_____
- I give permission for the nurse at school to share information with the prescriber about my child and this medication. Yes__ No___

Parent/Guardian
Signature:____Date_______________

Prescribing Provider
Signature:____Date:______________