

Union County Public Schools Medication Consent Form

School:

Telephone:

Fax:

Student Name _____ Birthdate _____

Teacher/Grade _____

In order to help protect your child's health, your consent **and** written authorization from a health care provider with prescriptive authority is required when it is necessary for your child to receive prescription and/or non-prescription medicines.

Parent or Guardian's Permission: I give permission for my child to receive this medicine during school hours. I also give permission for school staff to contact the prescribing healthcare provider with questions/concerns. I understand that it is my responsibility to purchase and supply this medicine in its original container. On behalf of my child I absolve the Union County School Board and their agents and employees from any and all liability whatsoever that may result from my child taking this medicine at school.

Signature of parent or guardian Date _____ Contact numbers (telephone, cell phone, pager, etc.) _____

☐ This is used for emergencies only*******Both sides of this form are required for emergency self carry medications*******

Below must be filled out by the Doctor/Health Care Provider. A separate consent form is required for each medication:

Medication _____ Strength/Dose _____

Medical Diagnosis: _____

Specific Directions (include amount to give, at what time and/or how often, relationship to meals, specific indications if "as needed")

How often and/or at what time (hour): _____

Purpose of medication: _____

Relationship to meals, if applicable: _____

Expected side effects or adverse reactions: _____

Specific indications: _____

Other information: _____

It is necessary for this student to receive this medication during school hours in order to maintain or improve health and to benefit from school attendance. Please notify the principal and/or school nurse and parents/guardians if there are any problems.

Signature of Healthcare Provider Date _____ Telephone _____ Fax _____

Please print practitioner's last name **Practice name /address**

FOR SCHOOL USE ONLY:

Date Received/By: _____ School Health Nurse Review: _____

Location of Medicine ☐ on student, emergency medication only ☐ in Health room ☐ in Classroom