

## CONSENT FOR ADMINISTERING MEDICATION AT SCHOOL

Short-Term Prescription       Inhaler - not self carrying       Over-the-Counter Medication

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_\_ Grade: \_\_\_\_\_

Student ID#: \_\_\_\_\_ School: \_\_\_\_\_

Teacher (Elementary Only): \_\_\_\_\_ Room#: \_\_\_\_\_

Medication: \_\_\_\_\_

Reason for Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

Time of Day to be administered: \_\_\_\_\_

Duration: \_\_\_\_\_ to \_\_\_\_\_

Physician Name: \_\_\_\_\_

Physician Phone: \_\_\_\_\_ Physician Fax: \_\_\_\_\_

### PARENT/GUARDIAN CONSENT

I DO  I DO NOT  specifically consent to transmission of my child's medical records via facsimile (fax).

I give my consent for the school designated personnel to administer the listed medication.  
All medication must be hand delivered by an adult and in it's the original container.

Note: Physician's permission is required in order for medication to be administered for an extended period or quantity other than listed on the label.

I authorize the physician to speak with the registered nurse regarding my child and this medication.