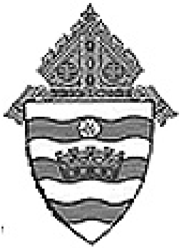

THIS SIDE FOR SHORT-TERM MEDICATIONS

Parent/Guardian Medication Consent Form

(Please type or print)

Name of School: ______________________________

Address of School: ______________________________

Telephone No. of School: ______________________________

Name of Child to be Medicated: ______________________________

Name of Drug and Dosage: ______________________________

Hour(s) Medication to be given: ____________________ No. of Days: __________

Name of person(s) who will be giving Medication during school hours: ____________________

____

(To be completed by the school principal or nurse)

Name of Physician Prescribing Medication:______________________________

Physician's Phone No.: ____________________

I hereby give permission to the Health Room/Office Personnel to give the medication so to my child according to the directions stated above and further authorize them to contact the child's physician. I agree to hold the above-named school, its employees and agents who are acting within the scope of their duties, harmless in any and all claim arising from administration of this medication at school.

I agree to notify the school, in writing, at the termination of this request or when any change in the above order is necessary.

______________________________ ____________________

Signature of Parent/Guardian Date

____

Address

____________________ ____________________ ____________________

Home Phone Work Phone Beeper/Cell No.