CONSENT FOR MEDICATION

Student Name_____

School_____ Grade_____ Teacher_____

Medication_____ Dosage_____

Date Medication Started_____ Expected Duration_____

Time of day medication is to be given at school and any special direction_____

_____

Date_____ Signature of Physician_____

PARENTS PLEASE READ THE FOLLOWING.

I hereby give my consent for _____to take the above prescription at school as ordered. I understand that my responsibility is to furnish the medication. I further understand that any school employee who administers any drug to my student in accordance with written instructions from the physician or dentist shall not be liable for damages as a result of an adverse drug reaction suffered by the student as a result of administering such drug.

Date_____ Signature Parent/Guardian_____

**In order to avoid unexpected reactions in the school setting, the first dosage of medication must be administered at home.

NOTE: **The medication must be brought to school in the original container correctly labeled by the pharmacy or physician stating the name of the medication, correct dosage, and times to be administered.**

MEDICATION GIVEN AT SCHOOL

Parent/Guardian_____Physician_____Phone_____

Medication	Prescribed by	Dosage	Time given	Duration of orders

Date	Time	Med. and Dosage	Administered by(Signature)	Comments