st.croixprep

School Year: _____

Consent for Medication Administration

LICENSED PRESCRIBERS ORDER FOR ADMINISTRATION OF PRESCRIPTION MEDICATION

I authorize the student to receive the following medication at school to be dispensed by the school nurse or designated school personnel. I give Health Service Staff permission to communicate with ordering provider about this medication. I release school personnel from any liability in the administration of this medication at school.

Student Name:_____ Grade:_____

Medication:_____ Dosage:_____ Time_____

please indicate before or after lunch when dosing for lunch times as lunch times can vary. Medication needs to be in original container with prescription label

Possible side effects:_____

Licensed Prescribers Signature:_____ Date:_____

Licensed Prescribers Name:_____ Clinic Name:_____

Clinic Phone Number:_____

New medication forms and health plans are required each school year

Parent/Guardian Signature:_____Date:_____

___ I will pick up all medication from Health Office by the last day of school

___ Please send home all medication in my student's backpack on the last day of school

*Certain medications need to be picked up by a parent and cannot be sent home. The Health Office will contact you if this is your students medications

PARENT CONSENT FOR ADMINISTRATION OF OVER THE COUNTER MEDICATION

I request this medication be given as stated on container, to be given by school nurse or designated school personnel. I release school personnel from any liability in the administration of this medication at school.

Medication:_____Dose:_____

Medication:_____Dose:_____

Medication:_____Dose:_____

Parent/Guardian Signature:_____Date:_____

Phone:_____

___ I will pick up all medication from Health Office by the last day of school

___ Please send home all medication in my student's backpack on the last day of school