PARENTAL CONSENT AND PHYSICIAN'S ORDER FOR MEDICATION
(For students who require medication given by school personnel during school hours)

TO BE COMPLETED BY PARENT/GUARDIAN: Date of Request: _____

Child's Name: _____ Birth Date: _____ School: _____

I give permission for my child (named above) be given the medication as indicated in the physician's order below. I am aware that non-medical personnel will be administering this medication to my child. I hereby release the school administration, their agents and their employees from any and all liability that may result from my child taking the prescribed medication. I also give the school staff/school nurse permission to contact the prescribing health care provider with questions/concerns.

_____	_____	_____
Parent/Guardian Name (PRINT)	Parent/Guardian Signature	Best Contact Number(s)

TO BE COMPLETED BY PHYSICIAN:

IT IS NECESSARY THAT THE ABOVED NAMED CHILD RECEIVE THE FOLLOWING MEDICATION DURING THE SCHOOL DAY. PLEASE ADMINISTER THE FOLLOWING AS DIRECTED BELOW:

Name and form of medication: _____

Dosage: _____ Time(s) to Be Given: _____

Route of Administration: _____

Medical Diagnosis: _____

Other Specific Directions: _____

Side Effects to Watch for: _____

Duration of Order: _____

Is the student allowed to self-carry / self-administer? (Emergency medications only) ❑ **Yes** ❑ **No**

Physician's Signature: _____ Date: _____

Physician's Name and Address: _____ Phone: _____
(Please print or use stamp)
_____ Fax: _____

Reviewed by School Nurse _____ Date_____

Student Homeroom: _____ Medication Expiration Date: _____