

**Consent for Medication Administration**

Note: If possible, parents are advised to give medication at home and on a schedule other than during school hours. If it is necessary that a medication be given during school hours, the following must be followed:

1. Medication must be ordered by a licensed prescriber and permission granted to the school nurse to contact the prescriber, if necessary.
2. All medications must be delivered to school in a pharmacy or manufacturer-labeled container by parent or guardian. In extenuating circumstances, other arrangements may be made in advance by contacting the school nurse.
3. No more than a 30-day supply should be delivered to the school.

If you wish us to administer medication to your child, please complete and sign the form below:

**Please note: I understand that I may retrieve the medication from the school at any time and that the medicine will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.**

**GENERAL INFORMATION**

(Please Print)

Student: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_  
 Parent/Guardian: \_\_\_\_\_  
 Relationship to Student: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Other phone where parent can be reached: \_\_\_\_\_  
 Other medications currently administered to this student: including those given outside the school day.  
 (Please list all medicines including those given outside the school day.) \_\_\_\_\_  
 Known Allergies: \_\_\_\_\_

**CONSENT**

1. I give permission to the school nurse or designated personnel to administer the following medication:

\_\_\_\_\_ (name of medication, dose and times to be given in school)

prescribed by: \_\_\_\_\_ to \_\_\_\_\_  
(licensed prescriber) (student)

for the purpose of treating \_\_\_\_\_, and I give my permission for the school nurse to contact the licensed prescriber. (condition)

2. I give permission to the school nurse to share with appropriate personnel information relative to the prescribed medication as determined necessary for my child's health and safety.

Signature of Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_