Medication Consent

To be completed by the parent or guardian:

I request that my child _____ DOB _____ receive the medication as prescribed below by our physician. The medication is to be delivered to me in the properly labeled original container from the pharmacy.*

Signature (Parent or Guardian): _____

Telephone: Home _____ Work _____ Date _____

To be completed by physician:

I request that my patient, as listed below, receive the following medication:

Name of Student _____ DOB _____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment: _____

Possible Side Effects and Adverse Reactions (if any): _____

_____

Physician's Signature: _____ Date: _____

Address: _____ Phone: _____

* Medication must be in **original labeled container** with specific orders and name of medication.
* Medication and refills must be **brought to school by parent, guardian or responsible adult.**

Plan reviewed with parent(s)/guardian(s):

Parent Signature: _____ Date: _____