Parent/Guardian Medication Consent Form

(Please type or print)

Full name of child to be medicated:_____

Name of drug and dosage:_____

Hour(s) medication to be given:_____Number of Days:_____

Name of physician prescribing medication:_____Phone:_____

Reason for medication:_____

_____

Name of person(s) who will be giving medication during school hours:_____

_____

(to be filled out by school principal or nurse)

I hereby give permission to the above named persons to give the medication(s) to my child according to the directions stated above and further authorize them to contact the child's physician. I agree to hold the School, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.

I agree to notify the school in writing at the termination of this request or when any change in the above order is necessary.

_____ _____

Signature of Parent/Legal Guardian Date

_____

Address

Copies to:

Principal - White
Nurse - Canary
Physician - Pink
Parent - Gold