# PHYSICIAN/PRACTITIONER MEDICATION CONSENT FORM
Evansville Community School District

Prescription Medications

Specify one medication per form

## PHYSICIAN/HEALTH PRACTITIONER SECTION

Please administer to _____ the following medication at school:
(Student's Name)

Medication: _____ Dose: _____
Start Date: _____ End Date: _____
Method of Administration: _____ Time/Frequency: _____
Diagnosis:_____
As needed for _____, but no more frequently than every _____
Special Instructions:
_____
_____

Inhalers & EpiPen's:

- ☐ May carry on his/her person. This student has been instructed in the proper use of this medication and is sufficiently responsible to self-administer.
- ☐ May not carry inhaler or EpiPen on his/her person

_____
Physician Name Phone Fax

_____
Clinic/Facility

_____
Physician/Health Care Practitioner Signature Date