Approved: 3/11/2020 453.4 Form

MEDICATION CONSENT FORM

Student Name:	Date of Birth:
School:	Grade:

PARENT INFORMATION
OVER-THE-COUNTER MEDICATION (TO BE COMPLETED BY PARENT/GUARDIAN)

Medication Name	Dose	Route	Daily/PRN	Time/Frequency	Duration

PARENT INFORMATION (NEEDED FOR ALL NON-PRESCRIPTION MEDICATION)

Parent/Legal Guardian Consent:
I give permission for school personnel to administer the above medication(s) to my child according to practitioners and/or my instructions and authorize them to contact the practitioner if there is a question or concern.

Signature of Parent/Legal Guardian: ____

PRACTITIONER INFORMATION
PRESCRIPTION MEDICATION (TO BE COMPLETED BY HEALTHCARE PROVIDER)

Medication Name	Dose	Route	Daily/PRN	Time/Frequency	Duration

PRACTITIONER INFORMATION (NEEDED FOR ALL PRESCRIPTION MEDICATION)

Practitioner Name: ________________________________Phone: ______________________

Clinic/Facility: ____________________________________ Fax: ______________________

Practitioner Signature: ____

EPIPENS & INHALERS ONLY:

☐May self-carry Epipen or inhaler. This student has been instructed in the proper use of this medication and is sufficiently responsible to self-administer.

☐May not self-carry inhaler or Epipen.