Evansville
COMMUNITY SCHOOL DISTRICT

MEDICATION CONSENT FORM
Evansville Community School District

Medications are encouraged to be administered at home by parents/guardians whenever possible. If it is necessary for a student to receive medications at school, on field trips, or a school sponsored activity, all appropriate portions of this form must be complete prior to medication to be given at school. **One form for each medication is required.**

Student Information:

Student Name:	Date of Birth:
School:	Grade:

Medication Information:

Name of Medication:
Reason for Medication (Diagnosis):
Dose to be given at school:
☐Oral ☐ Inhaled ☐ IM ☐ Sub-Q ☐ Intranasal ☐ Rectal ☐ Topical ☐ Eye ☐ Ear ☐ Buccal ☐ Other _____
Time to be given at school:
As needed instructions:
Permission is valid for: ☐ Current School Year ☐ From (Date) _____ to (Date) _____

Parent/Guardian Consent (complete for ALL medication):

- I request and authorize that school personnel administer this medication/procedure at school.
- I will supply medication in its original, updated, pharmacy/manufacturer labeled container.
- I will obtain a new physician's order and notify the school with any changes in the medication (dose, time, route)
- I authorize the principle, assistant principal, or the school health office to exchange information verbally or in writing with my child's healthcare provider regarding this medication for any medication related concerns.
- I understand that all medication is to be transported to and from school by parent/guardian.

ASTHMA INHALERS ONLY: This student is capable of self-administration and can carry inhaler at school ☐ Yes ☐No
EPIPENS ONLY: This student is capable of self-administration and may carry an EpiPen at school ☐ Yes ☐No

My child attends Evansville High School and may carry and self-administer Over-the-Counter Medication ☐ Yes ☐ No

Signature of parent/guardian: _____ Date: _____

Physician Consent (complete for all PRESCRIPTION medication):

Healthcare Provider Name: _____ Phone: _____

Clinic/Facility: _____ Fax: _____

ASTHMA INHALERS ONLY: This student is capable of self-administration and can carry inhaler at school ☐ Yes ☐No
EPIPENS ONLY: This student is capable of self-administration and may carry an EpiPen at school. ☐ Yes ☐No

Signature of Healthcare Provider: _____ Date: _____