



Health Department

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MEDICATION ADMINISTRATION CONSENT FORM: Prescriptions

Student Name: _____ Grade/Teacher: _____

Birth Date: _____ Allergies: _____

NOTE TO PARENTS/GUARDIANS

The School District **REQUIRES** that students who need prescription medication during school hours **MUST** do the following:

1. Present a written consent form filled out and signed by the parent and **PHYSICIAN**. (Form below. If form is unavailable, a prescription pad form signed by the physician may be used.)
2. Bring the prescription medication in the original prescription container, properly labeled by a Pharmacist.

CONSENT FOR MEDICATION PRESCRIBED BY A PHYSICIAN

Medication: _____ Dosage: _____

Time to be given: _____

If needed, how often can administration of medicine be repeated? _____

Reason for Medication to be given: _____

Precautions: _____

If the medication is an inhaler, please answer the following questions:

Where is the inhaler to be stored?

- in designated area (health room, nurse's office)
- in student's possession
- in designated area & in student's possession (be sure to send 2 inhalers)

() I have instructed _____ in the proper way to use his/her inhaled asthma medications. It is my professional opinion that he/she should be allowed to carry and use this inhaled medication by him/herself.

() It is my professional opinion that _____ should not carry and use his/her inhaler asthma medication by him/herself.

Physician Signature/Phone _____ Date: _____

Parent Signature/Phone _____ Date _____

