ADMINISTRATION RECORD AND CONSENT FORM FOR PRESCRIPTION MEDICATIONS

STUDENT NAME: ____________________________________ GRADE: _______

DIAGNOSIS: ___________________________ ALLERGIES: _________________

MEDICATION: ____

DOSAGE: ____

AT WHAT TIME IS THE MEDICATION TO BE GIVEN? _________________________

HOW SOON CAN IT BE REPEATED? _____________________________________

ANTICIPATED NUMBER OF DAYS TO BE ADMINISTERED AT SCHOOL: ___________

ANTICIPATED SIDE EFFECTS: ____

PHYSICIAN ONLY:

MAY THIS STUDENT SELF MEDICATE WITH AN ASTHMA INHALER? YES___ NO___

PHYSICIAN SIGNATURE: ______________________________ DATE: _________

PARENT CONSENT:

I give permission for the above mentioned medication to be administered to my child during school hours. I understand that the school nurse who administers the above medication to my child, in accordance with the prescription or package directions, shall not be liable for damages as a result of an adverse drug reaction suffered by my child. I authorize the exchange of information between the school nurse and my child's physician regarding this medication and the related diagnosis. I further understand that it is my responsibility to supply the above medication in the original pharmacy labeled container, with a current date, and it will be delivered to school by a responsible adult not a student. I will notify the school nurse if there are any changes in my child's medication orders. I also understand that information regarding my child's medication orders may be shared with staff or emergency personnel on a need to know basis.

PARENT/GUARDIAN SIGNATURE: ____________________________ DATE: ___________

***Students are not allowed to carry any medications to school (including over the counter medications) with the exception of rescue asthma inhalers.