CONSENT FOR ADMINISTERING
A MEDICATION DURING SCHOOL HOURS

PART A: PARENTAL PERMISSION (to be filled out by the parent/guardian)

I hereby give my permission for my child, _____ to receive the medication as listed below during school hours. I understand that the school shall incur no liability for the administration of such medication. This medication has been prescribed by a licensed physician. I am bringing the medication in its original container or one appropriately labeled by a pharmacist or physician. I understand that this form must be completed by a doctor for both prescribed and over-the-counter medications. I hereby release the School and employees from any and all liability that may result from my child's taking the prescribed medication.

_____ _____ _____
Signature of Parent/Guardian Phone Number Date

PART B: PHYSICIAN'S AUTHORIZATION (to be filled out by the doctor)

_____ _____
Name of Child Date of Birth

In order to keep this child in optimum health and to help maintain maximum school attendance and performance, it is necessary that the following medication be given at school.

_____ _____
Name of Medication and Strength Classification (i.e. antibiotic, etc.)

Medication is: ____Chewable tablet _____Swallow tablet/capsule ____Liquid
____Nasal inhaler _____Oral inhaler Other:_____

Dosage:_____Time to be given at school:_____
Date to Discontinue_____

Relationship to meals: _____with meal _____before meal _____after meal
_____ not applicable

If medication is on a PRN (as needed) schedule, describe how person administering medication is to determine when the drug is needed:

_____

_____

Expected/predictable Side Effects:

_____

Any other specific directions or helpful information:

_____

_____ _____ _____
Physician's Signature Phone Number Date