# *ADMINISTRATION OF MEDICATION CONSENT*

***-Macon County School System-***

## Student Information

Student Name_____________________________________________ Date of Birth ________________

Diagnosis ______________________________________________________________________

## Healthcare Provider Statement

The health care provider may be a medical doctor (M.D), physicians assistant (P.A.), a registered nurse practitioner (FNP), or a dentist (D.D.S.).

**To be completed by health care provider:** (If non-prescription medication, parent must fill out)

Name and strength of drug: ______________________________________________________________

Dosage and time to be given at school:______________________________________________________

Start date___________________through_______________________

Does this medication absolutely need to be given during school hours? Yes_____ No _____

Possible side effects______________________________________________________________________

Healthcare Provider Name___________________________________ Phone______________________

Address_______________________________________________________________________________

**Healthcare Provider Signature ____________________________________ Date __________________**

## Parent/Guardian Information

I give consent for__________________________ to take his/her own medicine during the school day assisted by school personnel as necessary. All prescription medication must be labeled by the pharmacist and must be in the original container. If non-prescription medication, it must be in original container. I give consent for school personnel (school nurse) to contact my child's healthcare provider for information regarding the above orders.

**Parent Signature** ______________________________________ Date ______________________

Phone numbers ______________________________ (Cell)

______________________________ (Home)

______________________________ (Work)