Parent Consent form for the Student Medication Administration

I have read the medication label, and my child does not have any health problems that could be made worse by taking this medication. My child is not taking any other medication at home that could interact with this medicine and cause unwanted side effects. I will notify the school in writing if I want this medicine discontinued. Otherwise, I understand that it will be kept in the nurse's office and will be administered as listed below for the current school year by a designated school employee.

Fill out completely and return to school with the medication that will be administered.

Student:_____ **DOB:**_____

Teacher/grade:_____

Medication:_____

Prescription:_____ **Non-Prescription:**_____

Dosage:_____ **Expiration Date:**_____

Purpose:_____ **Times to be given:**_____

Dates to be given:_____ **Allergies:**_____

Prescription: Name of prescribing Physician:_____

Special Instructions:_____

I,_____**, (parent or guardian) give**

Permission to authorized staff member(s) to administer medication to my child

as indicated above.

_____ _____

Parent/Guardian Signature **Date**