



2018 – 2019 Academic Year

Parent's Consent for Giving Medication at School

I hereby request and give my consent for the school health clerk or person designated by the administrator to see that my child is given the medication indicated below. The medication will be furnished by me in the original container, labeled with the child's name.

1. Name of Student _____ Grade _____
2. Medication Name _____
3. Rx # and prescriber's name (if applicable) _____
4. Route of administration _____
5. Amount to be given _____
6. Frequency and time of day to be given _____
7. Expected duration of treatment: from _____ to _____
8. Reason for medication _____
9. Possible side effects _____

Parent/Guardian Signature

Date

Health Clerk/Designated Person Signature

Please notify the school immediately if there is a change in medication.

For Health Clerk's Use

Notes _____

Medication

Medication Count		Medication Count	
Lot #		Lot #	
Expiration Date		Expiration Date	
Initials		Initials	
Date		Date	

Medication Record

2018 – 2019 Academic Year

Student _____ Grade _____

Medication _____ Dose _____

Frequency _____ Route _____

Special Instructions _____

Reason for Medication _____ Emergency Contact # _____

	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
M										
Tu										
W										
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Medication Giver Signature and Initials _____