Union Academy Charter School

Nursing Department - Medication Consent Form

To be completed by Physican/Parent:

Student Name: _____ D.O.B: _____ Teacher/Grade: _____

Name of medication (one medication per consent form): _____

***** Please remember that medication must be supplied by the parent/guardian, be in the original container, labeled with child's name and not expired. Expired meds can not be given. *****

Scheduled Medication:

Dosage to be given: _____ Time(s) to be given: _____

Purpose of the scheduled medication: _____

As Needed Medication:

Dosage to be given: _____ Time(s) to be given: _____

Symptom for which medication may be given: _____

***** All medications will be kept in the health room. *****

Self Carry Medication:

EpiPen, insulin, or inhaler preferred location: ◯ Health room ◯ Classroom ◯ Self-Carry
(Self-carry consent required)

Physician's and Parent signature is required for any medication, prescription or over-the-counter.

_____ _____
Physician Name (Please Print) **Physician Signature**

(_____) _____ (_____) _____ _____
Physician Phone **Physician Fax** **Date**

I hereby give permission for my child, named above, to receive medication during school hours, during the after school program (Kids Incorporated), during athletic events or practices, and during field trips. I also give the school nurse or athletic trainer permission to contact the prescribing physician with any questions or concerns. I hereby release Union Academy and their agents from all liability that may result from my child taking this medication.

_____ (_____) _____ _____
Parent/Legal Guardian Signature **Daytime Phone** **Date**