Medication – Parent Consent Form

If your child has a medical condition that the school staff should be aware of, please complete the following information.

Medication should be brought to school appropriately labeled by the pharmacy and in the original prescription container accompanied by written side effects and emergency procedures. No medication may be administered if the date has expired, if the container label is missing or cannot be clearly read, or if more than one type of medication is in the bottle. Bubble packs are preferred and must be labeled and provide the same information as above.

Medication should be brought to school by the parent, not the student. The student should wear medical alert identification (i.e. bracelet) if he/she requires medication on a long-term basis or has a chronic condition.

If your child is required to take medication at school, please fill in the appropriate areas. Prescribed medication or over the counter drugs will be administered through the school office. All medication will be kept in a locked area.

Student Name: _____ **Grade:** _____

Parent/Legal Guardian Name: _____

Home Telephone Number: _____ **Work Telephone Number:** _____

Alternate Emergency Contact: Name: _____

Telephone Number: _____

Please include the name of other medication taken at home that medical personnel need to know about in case of an emergency.

Other medication taken at home: _____

I, the undersigned parent/legal guardian hereby waive all rights of action on behalf of myself and/or my child in case of any cause of action that may arise as a result of the principal/designate proceeding with my request for administering medication.

_____ _____

Parent/Guardian Signature **Date**

Please fill in the following if your child has a condition that needs to be monitored:

Condition: Allergies, asthma, seizure disorder, etc. _____

Symptoms to watch for: _____

	Medication #1 ☐ **Administer** ☐ **Monitor**	**Medication #2** ☐ **Administer** ☐ **Monitor**	**Medication #3** ☐ **Administer** ☐ **Monitor**	**Medication #4** ☐ **Administer** ☐ **Monitor**
Received medication in original container	☐ **Yes**	☐ **Yes**	☐ **Yes**	☐ **Yes**
Medication Information sheets provided	☐ **Yes**	☐ **Yes**	☐ **Yes**	☐ **Yes**
Name of medication				
Desired effect(s) of medication				
Plan of action in response to side effect(s) event				
Dose of Medication				
Route of administration				
Time(s) medication o be given at school				
Start date of medication				
Finish or review date of medication				
Location of medication administration /monitoring				
Name of staff person to administer/ monitor medication				
Name of alternative staff to administer/ monitor medication				
Special Instructions (please attach pharmacy printout)				