# Medication Consent Form

Student Name:_____ School_____

DOB:_____ Grade:_____ Primary Phone#:_____

| Over the Counter Medications | | | | | | | School shall contact the clinic for any of the following symptoms: |
|---|---|---|---|---|---|---|---|
| Medication Name: | Dosage | Route | Daily or As Needed | Time | Duration | Diagnosis/ Instructions/ Reason for Administration | |
| | | | | | From:<br>To: | | |
| | | | | | From:<br>To: | | |
| | | | | | From:<br>To: | | |
| | | | | | From:<br>To: | | |

| Prescription Medications (to be completed by Practitioner) | | | | | | | School shall contact the clinic for any of the following symptoms: | Emergency Medication Only. Practitioner to initial box below if student is able to carry and self-administer.ie Inhaler, Epinephrine. |
|---|---|---|---|---|---|---|---|---|
| Medication Name: | Dosage | Route | Daily or As Needed | Time | Duration | Diagnosis/ Instructions/ Reason for Administration | | |
| | | | | | From:<br>To: | | | |
| | | | | | From:<br>To: | | | |
| | | | | | From:<br>To: | | | |
| | | | | | From:<br>To: | | | |

**PRACTITIONER INFORMATION (needed for all prescription medication administered at school):**

Practitioner Name: _____ Phone: _____

Address: _____

The above prescriptions medications will need to be administered at school:

Practitioner's Signature:_____ Date: _____

**Parent/Legal Guardian Consent (needed for all medication at school):**

**Medication will be provided by parent and in its original container or prescription labeled container.**

I hereby give permission for school personnel to administer the above medication(s) to my child according to practitioner's and/or my instructions and authorize them to contact the practitioner if there is a question or concern. I further authorize the practitioner to render treatment to my child, as appropriate and necessary, arising out of administration of the medication.

_____ _____

Signature of Parent/Legal Guardian Date

In the event that your child will have some unused doses of medication left at the end of the school year, please advise the school on how you would like the medication returned by completing the following:

☐ I will arrange to pick up the unused portion of my child's medication.

☐ Please send the unused portion of my child's medication home with him/her at the end of the school year.

**I understand that I am responsible for making sure it arrives home safely.**

## Asthma Inhaler Administration Authorization Form

**Student's Name:**_____ **D.O.B:** _____**School/Grade:** _____

**Diagnosis:** _____

In order for the student to receive the asthma relieving medication for asthma:

- Asthma inhaler administration authorization form will be completed and signed by parent and medical provider. Form will be given to school district administrator or school nurse.
- Asthma inhaler medication will have student's name, name of medication, directions for use and date.
- Authorization of asthma relieving medication will be updated annually.

The student has the skill, knowledge and my authorization to use an asthma relieving medication in the following manner:

____ Self-administer asthma relieving medication. Student will seek the care of the school personnel if medication is unsuccessfully controlling his/her asthma.
____ Self-administer asthma relieving medication with access to another inhaler in the health office as needed. Parents will supply health office secondary inhaler.
____ Student needs assistance with administration of their asthma relieving medication with the medication available as needed in the health office.

| **Drug name:** | **Dosage:** | **Route:** | **Frequency:** | **Start date:** | **Stop date:** | **Side Effects:** |
|---|---|---|---|---|---|---|
| 1. | | | | | | |
| 2. | | | | | | |

School personnel may contact the medical provider of the medication for clarification regarding indication for use, medication, dosage, side effects, successful and treatment failures.

| | |
|---|---|
| Physician's name: | Clinic/Phone: |
| Physician's signature: | Date: |
| Parent/Guardian signature | Date: |

School Administrator Authorization: _____ Date: _____