

Prescription Medication Consent Form

Please complete this form if your child has a prescription medication that is required to be administered while at school.

- Please provide medication in its original and properly labeled container to school nurses' office. It is imperative that the prescription medication must be in the pharmacy-labeled container with the student's name clearly visible.
- Please inform school of any changes in the medication plan along with new orders.

| |
|---|
| Student Name: |
| DOB: |
| MEDICATION NAME: |
| DOSE: |
| TIME/FREQUENCY: |
| REASON FOR MEDICATION: |
| LENGTH OF TREATMENT: Medication will continue for _____ days or until _____ |
| ADVERSE REACTIONS TO MONITOR: |

I authorize school staff to assist with medication administration as directed by the authorized health care provider.

Parent/Guardian Signature

Date