MEDICATION CONSENT FORM

Commercial Township School

Student Name: _____ D.O.B._____

Grade/Teacher:_____

TO BE COMPLETED BY PHYSICIAN:

Diagnosis:_____

Name of Medication to be Administered: _____

Dose: _____ Time (s) to be given at school: _____

If PRN, provide criteria: _____

Length of time prescribed: Start Date: _____ Stop Date: _____

Precautions/Possible Side Effects: _____

Student needs to take medication while attending field trips? YES NO

Stimulant medication time(s) can be rescheduled to (time) _____ on field trip days.

Physician's Name (printed): _____ Physician's Signature: _____ Date: _____

Address: _____ Telephone # _____

To Be Completed By Parent/Guardian:

I give permission for the school nurse at Commercial Township School to administer the above medication, as prescribed by my child's physician, to my child _____. I understand that no medication will be given to my child unless it is brought to school in the original container and properly labeled from the pharmacy/manufacturer. I authorize, as needed, the sharing of information related to my child's health between the school nurse and the healthcare provider listed above.

Please administer the above named medication to my child on early dismissal days: Yes _____ No _____

Signature of Parent/Guardian: _____ Date: _____