

MEDICATION/TREATMENT CONSENT FORM



Student Name _____

Birth Date _____

School Year _____

Diagnosis/Condition _____

CONSENT FOR ADMINISTRATION OF HEALTH TREATMENT and/or MEDICATION AT SCHOOL

- Parents are urged to provide health treatments and give medication at home and on a schedule other than school hours if possible. If it is necessary that treatments and/or medication be provided during school hours, these regulations must be followed. *Please Note: "Medication" refers to any prescription, non-prescription, homeopathic, herbal, vitamin, or mineral preparation.*
- Health treatments and medications must be prescribed in writing by a physician or other licensed health care provider and must be renewed at least annually on or after July 1. Providers complete Part 1 below and must sign form—Part 2 and fax written instructions to school.
- All medication, prescription and non-prescription, must be brought to school in the original pharmacy container with a current label showing the name of the student, medication, strength, dosage, and time(s) to be given. Only the parent/guardian or other responsible adult or the pharmacy may deliver the medicine to school. Students are not allowed to bring their own medication to school.
- Health treatment supplies will be provided for school use for each student by parent/guardian as needed.
- Parent/guardian written permission is required to administer treatments and medications at school as directed by physician/licensed health care provider, including permission to contact the provider as necessary. Parents must sign below—Part 2.
- If your child is Medicaid eligible, school health services may be billed on behalf of the school. School district billing will not impact future benefits of your family's Medicaid plan.

PART I: PHYSICIAN/HEALTH CARE PROVIDER INSTRUCTIONS

MEDICATION/TREATMENT	DOSE	ROUTE	TIME/FREQUENCY

Recommendations, Special Considerations, Side Effects, Precautions, Allergies:

PART 2: AUTHORIZATION SIGNATURES

The following signatures serve as written authorization for permission to administer health treatment and/or medication as directed at school. Authorization includes permission for school personnel and health care providers to contact each other. Medication and Treatment information is kept confidential but it may be shared with appropriate staff as needed.

Physician/Provider Signature: _____ Date: _____ Phone: _____

Print Name of Provider: _____ Fax: _____

Parent/Guardian Signature: _____ Date: _____ Phone: _____

ONLY IF APPLICABLE – Self carry/administer medication – Emergency Medication ONLY

Student is capable and responsible for self-administering the above prescription: ☐ Yes-Unsupervised ☐ Yes-Supervised ☐ No

Physician/Provider Signature: _____ Date: _____

Print Name of Provider: _____ Phone: _____

I give permission for my child, _____, to self-administer self-carry the above medication at school.

Parent/Guardian Signature: _____ Date: _____

School Nurse Reviewed: _____ Date: _____