Consent for Medication Administration
District 511

ALL PRESCRIPTION MEDICATION REQUIRES A PHYSICIAN'S SIGNATURE

Student: _____ Date of Birth: _____ Grade: _____

School: [ ] Elem [ ] Middle [ ] Sr. High School Year: _____

Parent/Guardian Name: _____ Phone: (H) _____ (W) _____

1. **Reason** for medication/treatment: _____
2. Name of **Medication:** _____ **Dosage:** _____
   ( ) tablet/capsule ( ) liquid ( ) inhaler ( ) nebulizer ( ) other
3. **Time** medication is to be given **AT SCHOOL**: _____ ( ) with lunch
4. Start Date: _____ ( ) end of school year, ( ) until further notice from parent or M.D.
5. Restrictions and/or side effects: _____ ( ) non-anticipated
6. **For students with more than once daily dosing**: If the morning dose usually taken at home is missed, this dose may be administered at school by school personnel. PARENT/GUARDIAN is required to notify school of missed dose at home.

For Insulin, Epi-pens, inhalers, & nebulizers: I have assessed this student and found him/her to be both capable and responsible for SELF-ADMINISTERING/SELF CARRYING this medication (school district is not responsible for missed doses of medication):
( ) not applicable, ( ) no, ( ) yes, with supervision ( ) yes, unsupervised – may carry during school hours

_____ _____
Physician's Signature (for ALL prescription medications) **Date**

_____
Physician name - printed
*a photocopy of the prescription is acceptable in place of physician's signature unless the student is going to self-administer/self carry the medication.

I authorize school personnel to set-up and administer the above medication to my child (unless self administration/self carry has been indicated). I understand that the **medication must be provided in a pharmacy or unopened manufacturer's labeled bottle.** Medication in plastic bags or white envelopes WILL NOT be accepted.

***This notice gives permission for the school health office and this doctor's office to share information regarding this student's health condition to better care for the child during school hours. I give my permission for my child's medical office to fax this form to my child's school.

_____ _____
Parent/Guardian Signature **Date**