Parental Consent for Medication Administration

Date: _____ School: **St. Clare of Assisi** Fax # 636-394-0359

Student: _____ Grade/Teacher: ____/_____

My child is to receive_____ **(medication)** according to the physician's directions to treat _____ **(condition)**. This treatment will last from _____ **to** _____ **or the entire school year**. I give my permission for this medication to be dispensed to my child at school. I also give the school permission to contact the physician with questions regarding the medication, if needed.

My child has drug allergies to: _____

Signature: _____ Relationship: _____

Physician Consent for Medication Administration

Student: _____ Date: _____

Medication: _____

Dose/Frequency: _____

Diagnosis or reason for treatment: _____

Observe for these side effects: _____

Signature: _____

********************************HEALTH ROOM USE ONLY********************************

Medication: _____ Dose/Frequency: _____

Date/Time/Initial	Date/Time/Initial	Date/Time/Initial	Date/Time/Initial	Date/Time/Initial	Date/Time/Initial

Initial/Signature ____/_____ Initial/Signature ____/_____

Initial/Signature ____/_____ Initial/Signature ____/_____

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