Medication Consent Form

Full Name of Child _____

Name of Drug and Dosage _____

Hour to be given _____ Name of Physician Ordering Drug _____

Phone Number _____

Starting Date _____ Termination Date _____

Reason for Medication _____

Specific Instructions _____

I hereby give my permission to school personnel to give the medication according to the directions stated above, and to contact the child's physician if necessary. I further agree to hold the School District of Cameron and the above person harmless in any and all claims from the administration of this medication at school. I agree to notify the school in writing when any changes in the above orders are necessary.

_____ _____

Signature of Parent/Guardian Date

*This Form must be returned to your child's school before school staff can administer medication!

School District of Cameron

Request for Physician Order for Medication Administration

Dear Dr. _____

Personnel in the School District of Cameron have been asked to administer medication for this child in the school setting. School personnel without this order will administer no prescription medication. Please complete and return to the child's parent with the prescription.

Name of Student _____

Address_____ Phone _____

School _____ Grade _____ Diagnosis _____

Medication _____

Dose/Route/Frequency/Duration _____

Contact Physician If _____

_____ _____

Physician's Signature Date