ADMINISTRATION OF MEDICATION TO STUDENTS
CONSENT FORM

If a student is 18 or older the student signature is required

Name of Student: ____

Student's Address: ____

Student's Phone Number: ____

Parent's Phone Number: ____

Physician's Statement (required only if school personnel are to supervise medication at school)

1. Name of Medication: ____
2. Reason for Medication: ____
3. Dosage and time(s) student is to take medication at school: ______________________
   ____
4. Duration (week, month) ____
5. Precautions and reactions to observe and report: ______________________________
   ____

________________________________	____________________	__________
Physician's Signature	Telephone Number	Date

Parent's Statement (Initial Agreement Statement)

_______ I request and authorize personnel at the Montrose School District to supervise the self-administration of medication prescribed on this form to my child. I understand that the medication must be provided in a bottle, identifying the name and telephone number of the pharmacy, the student's name, physician's name and dosage of the drug the student is to take. I understand that the school district and individuals involved will not be held liable for any adverse effects of the medication.

____	_______________
Parent's signature	Date

Adopted: July 11, 2022