REQUEST TO PROVIDE MEDICATION DURING SCHOOL HOURS
Columbus Public Schools
Health Services

IMPORTANT INFORMATION FOR PARENTS/GUARDIANS:
Medication may be administered at school when such treatment is necessary for school attendance and cannot otherwise be accomplished. Your written consent is required **prior** to school personnel administering medication to a child in school. By signing below, you acknowledge the following:

- If needed, the prescribing physician may be contacted by the school nurse for clarification on medication administration.
- Your child's medication may be given by a school nurse, health aide or by other deisignated school personnel.
- The school health office should be notified promptly if there are changes in your child's medication orders.
- All medication products must be sent to the school in the original container with label intact.
- Parents/Guardians are encouraged to provide one to two weeks' supply of medication.

WRITTEN PARENTAL CONSENT

Name of Student: _____Grade:_____

Name of Medication:_____ Dose:_____

Time(s) and Dose to be given: _____Time given at home:_____

Reason for medication:_____

Form of Medication: ▢ Capsule/Tablet ▢ Liquid ▢Inhaler/Nebulizer ▢ Injection ▢ Other

Special Administration procedures:▢Crush pill ▢With food ▢None ▢Other_____

Special Storage requirements: ▢ Locked Storage ▢ Refrigeration ▢ None

Any anticipated Side Effects or Restrictions:_____▢ None Anticipated

Prescribing Physician:_____

Medication start date:_____ Discontinue date:_____

I hereby give permission for my student _____ to take the above prescribed medication at school. I absolve school personnel and the school district from liability stemming from adverse reactions and all other adverse effects which may occur because of the administering of such prescribed medication.

_____/_____ Date_____ Telephone_____
Signature Parent/Guardian Relationship

For office use

Date Form Received:	Staff Initials:

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