MEDICATION CONSENT FORM

Name of child: _____

Name of medication: _____

Prescription: _____ Non-Presciption: _____

Dosage: _____

Date medication to be given (ex: everyday): _____

Time medication to be given: _____

Reason for medication: _____

Possible side effects: _____

Action/treatment for side effects: _____

_____

Directions for storage: _____

Name & phone number of prescribing physician: _____

_____

I, _____ (parent or guardian) give my consent

to authorized North Border School staff member(s) to administer medication to my child as indicated above.

_____ _____

Signature of Parent/Guardian **Date**