MEDICATION CONSENT & ADMINISTRATION RECORD

Student Name: _____ Date of Birth: _____

• Medication will be administered during school hours only when their health requires it.

• It is the Parent/Guardian responsibility to bring medication to school, in its original container.

• All over-the-counter medications must be clearly marked with the student's name.

• Prescription medications must include the following information on the label: Student Name, RX number, Pharmacy name and phone #, RX date, ordering Physician's name, medication name, dosage, and route of administration. Medication will be counted upon receipt and return and will only be dispensed as prescribed by the Physician. ***Physician signature must be present on this form for a prescription medication to be dispensed.***

• It is the Parent/Guardian responsibility to remove any unused portion of medication when treatment is completed.

Parental Consent for Student Medication Use:

_____ I consent that school personnel assist my student with administration of the following medication during school hours.

_____ I declare that my student is able to administer the medication with assistance from staff and I assume full responsibility.

Medication Name: _____Dosage:_____

Route of administration: (circle route) by mouth inhalation injection topical (Skin)

Reason medication is to be taken: _____

Time medication is to be taken: Daily at _____ AM/PM or PRN/Every _____ hours as needed

Ending date of medication: _____ or Medication may be used until: _____

Parent/Guardian Signature_____ Date_____/_____/_____

Parent Contact phone #_____Emergency Contact #_____

Physician Signature : _____ Date_____/_____/_____

Prescription Medication Count Record

Date	Time	# Received On this date	# Returned On this date	Nurse (or designee) Signature	Parent/Guardian Signature

Pill counts REQUIRE two signatures. ANY discrepancies are to be reported to the CNM and SRO immediately.