El Dorado Public Schools
MEDICATION ADMINISTRATION CONSENT

Date: _____ Current School Year: _____

To: _____ _____
Name of School Principal of School

I request that you give medication to my child during the school day in accordance with the Board of Education policy printed below. You are authorized to delegate this authority to another person if so desired.

Medication Policy

1. Medication *must* be in the original container with the student's name on the prescription bottle. Only *one* medication per bottle.
2. No medication to be given (3) times daily or *less* will be administered at school if it can be administered before and after school without interfering with the therapeutic effect. If medication to be given at a *specific* time this *must* be included by the physician on the prescription directions.
3. Non-prescription, or over the counter medications, will not be given for more than one week without a *completed* Medication Administration Consent meaning the Physician's signature is *required.*
4. The consent form *must* be signed by both the Parent or legal guardian, *AND* the physician *BEFORE* any medication will be given at school. HANDWRITTEN NOTES ARE *NOT* ACCEPTABLE.

I will not hold the school staff responsible for any undesired reaction which may occur from the medication. I agree to pay for ambulance services if used to transport my child from school to the doctor or hospital should he/she have an adverse reaction to the medication. The School Nurse (or designee has my Permission to take a photograph of my child for identification purposes.

Parent/Guardian's Signature: _____

Student's Name: _____ Date of Birth: _____

Name of Medication: _____ Dosage: _____

Time(s) to be given: _____ Expected duration of treatment: _____

Reason for medication (diagnosis): _____

Physician's signature: _____ Date: _____

In event of emergency call: _____ Phone: _____

Cell: _____ Pager: _____ Work: _____

I certify that *at least one dose* of the medication has *previously been given* and NO adverse reaction was experienced. Therefore, I give my permission for the school nurse (or trained designee) to administer the above medication to my child.

Parent/Guardian's Signature: _____ *Date:* _____

Note Medication must be brought to school by an Adult & MUST BE in *correctly* labeled container from the pharmacy. The medication will only be administered according to the *typed* directions on the container.

Date	Pill Count	Brought by:	Bottle Sent Home:	Initials/Initials	Comments

(Medication Administration Record on back. *Each* Medication requires a completed Medication consent)