# CONSENT / CONTRACT FOR INDEPENDENT ADMINISTRATION OF PRESCRIPTION AND NON-PRESCRIPTION MEDICATION AT SCHOOL FORM

Please check here if **NON**-prescription ☐

Student Name _____Grade:_____Birthdate _____

For prescription medication, the physician must complete the information required below. Medication must be delivered to school in the original container with the label intact, and is to be given in the following manner: If any changes in medication or dosage occur, the school must be notified immediately, and a new form must be completed.

Name of Medication: _____

Strength of Medication: _____

Amount to be given: _____

Time of Administration at School: _____

Route of Administration (by mouth, etc.):_____

Comments and/or Instructions: _____

Reason for Medication: _____

Date Medication is to be discontinued: _____

Physician's Name:_____

(Please print)

_____

Physician's Signature Date

I hereby request and give my consent for my child to INDEPENDENTLY take the medication indicated above. . I will assume full responsibility for the supply, appropriate transportation and maintenance of prescription medication. I hereby give permission for the exchange of information regarding my child's medication. The following member of the school administration is aware of this and has approved of this:

_____

Administrator Name/Signature Date: _____

_____

Parent/Guardian Signature Date; _____