5703-F-2 Consent for District Administered Medication Form

Student Information

Student's Name: ____

Date of Birth: ______________________ Grade: ________________

Healthcare Provider Information

Name/Title: ____

Address: ____

Telephone: ____________________ Fax: ______________________

Provider Signature: ___________________________ Date: __________

Medication Information

This section must be completed by the Student's healthcare provider.

Medication Name: ____________________ Dose: ________________

Administration Method: ___________ Administration Time/frequency: ________

If "as needed," under what conditions is the medication to be administered:

____

Relevant side effects: ____

____

Parent/Guardian Consent

I, ________________________ , authorize school staff to administer medication accordance with this form and applicable Policies. I acknowledge that Board Policy requires that I immediately inform the District of any changes to the healthcare provider's medication instructions.

Parent's/Guardian's Signature: ______________________ Date: __________

Home Phone: ____________________ Cell Phone: ____________________

Work Phone: ____________________ Email: ____________________

(Please circle which phone number you would like District staff to call first.)

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