De Soto Area Schools

Parent / Guardian Consent for Medication Administration Form

For PRESCRIPTION MEDICATION:

- Complete the Parent/Guardian Consent portion in full with signature.
- The Physician Order for Medication portion must be completed & signed.
- Return completed form and pharmacy-labeled medication to school office.

For NON-PRESCRIPTION MEDICATION

- Complete the Parent/Guardian Consent portion in full with signature.
- Return completed form and accurately labeled medication to school office.

Parent / Guardian Consent Form

Student Name _____ Grade _____ School _____

Birth date _____ Medication Name_____

Dosage _____ Dates & time to be taken _____

Physician's Name _____ Physician's Phone ( ) _____

Reason for medication _____

* I hereby grant permission for my student to take medication at school as ordered, and authorize school personnel to contact my child's physician if necessary.
* I agree to provide school personnel with the medication in its original, properly labeled container.
* I agree to provide written notice to terminate this request, or when any change in medication is necessary.
* I agree to release the school district from any and all liability claims arising from the administration of medication at school.

Parent /Guardian Signature _____ Date _____

Physician Order for Medication

I hereby grant school personnel permission to administer this medication.

Medication _____

Dosage / Schedule _____

Contact me if the following symptoms occur:

_____

_____

Physician's Name _____ Signature _____

Date_____ Office _____Phone ( ) _____