

# In-School Medication Parent Consent Form

## Student Information

Student Name

Grade

Date of Birth

School

## Medication Information

Medication Name

Dosage

Time(s) to be Given

Route (Oral, Topical, etc.)

Purpose of Medication

Special Instructions

Possible Side Effects

# Parent/Guardian Consent

I authorize school personnel to administer the medication as described above to my child, and to contact the prescribing physician if necessary.

Parent/Guardian Name

Signature

Date

Phone Number

Emergency Contact Name

Emergency Contact Phone

## Physician Authorization (if required)

Physician Name

Phone Number

Signature

Date