# Student Medication Administration Consent Form

## Student Information

Student Name

Date of Birth

Grade

School

## Medication Information

Medication Name

Dosage

Route (e.g., oral, topical)

Time(s) to be Administered

Reason for Medication

Special Instructions

## Parent/Guardian Consent

I authorize the school staff to administer the above medication to my child as specified above. I understand that all medications must be delivered to the school in the original container and appropriately labeled.

Parent/Guardian Name

Signature

Date

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**Healthcare Provider Authorization (If Required)**

Provider Name

Signature

Date

Provider Phone