For Office Use Only:
Date Received:_____
Received by (initials): _____
Approved (Y/N): _____

PRESCRIPTION

MACCRAY Schools

School Consent Form for Administration of **Prescription** Medication

Please be aware staff at school and 911 personnel may be informed of your child's diagnoses and m
such knowledge would benefit their care or education.

Parents of students requesting medication be administered during school hours by school staff are required to provide for the school:

1. A ***written parental release*** for the administration of medication and
2. A ***signed statement*** from the Health Care Provider (as indicated by school policy) and
3. The medication must be in the ***original*** container
4. Physician's Order

STUDENT'S NAME: _____ BIRTHDATE: _____

PARENT/ GUARDIAN: _____ GRADE/ Teacher: _____

SCHOOL: _____

Print Medical Providers Name and Clinic: _____

_____

To be Completed by PHYSICIAN or AUTHORIZED PRESCRIBER

1. MEDICATION: _____

☐ Tablet/ Capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other

If Other, Please Describe: _____

2. ROUTE, DOSAGE ***AND*** TIME of Administration: _____
   Medication **SHOULD** be used for Field Trips: ☐ Yes ☐ No

3. ***REASON*** for Medication (***DIAGNOSIS***): _____

4. ***START DATE:_____STOP DATE:_____*** ☐ End of School year

5. ***Restrictions*** and/ or important ***Side Effects:*** ☐ **None Anticipated**

   ☐ **Yes, Please Describe: _____**

6. **Allergies:** ☐ **No known Allergies** ☐ **Yes, Please list: _____**

7. This student is both capable and responsible for **Self-Administering** this medication **(Subject to School Policy)** ☐ **No** ☐ **Yes: Supervised** ☐ **Yes: Unsupervised**

PROVIDERS SIGNATURE:_____DATE:_____

PARENTAL RELEASE FOR ADMINISTRATION OF MEDICATION

I request that the above medication be given at school as prescribed by the physician. I understand that I must provide this medication in the ***ORIGINAL*** container labeled by the pharmacist. I understand that the school will not assume responsibility for medications self-administered. I authorize my child's school to release and exchange information with their health care provider.

PARENT/ GUARDIAN Signature: _____ Date: _____

Home Phone _____Work Phone _____

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Approved (Y/N): _____

PRESCRIPTION

MACCRAY Schools

School Consent Form for Administration of **Prescription** Medication

ADDRESS: _____ ***PHONE:*** _____

PARENTAL RELEASE FOR ADMINISTRATION OF MEDICATION

I request that the above medication be given at school as prescribed by the physician. I understand that I must provide this medication in the ***ORIGINAL*** container labeled by the pharmacist. I understand that the school will not assume responsibility for medications self-administered. I authorize my child's school to release and exchange information with their health care provider.

PARENT/ GUARDIAN Signature: _____ Date: _____

Home Phone _____Work Phone _____