Medication Administration Consent

(One form per medication)

To Be Completed by Health Care Provider with Prescriptive Authority:

Child's Name: ______________________ **Birthdate:** ____________

Medication: ______________________

Dosage: ______________________ **Route**: ____________

Time of Day Medication Is To Be Given: ______________________

Special Instructions: ______________________

Purpose of Medication: ______________________

Possible Side Effects: ______________________

Start Date: ______________________ **End Date:** ____________

(valid 1 year from start date unless otherwise specified)

Signature:

______________________ ____________

(Signature of Provider with Prescriptive Authority) (Title)

______________________ ____________

(Printed Name) (Date)

Office Stamp:

(or print address, phone, and fax number)

To Be Completed by the Parent or Guardian:

I grant permission for my child to take the above medication at Bal Swan as ordered by the health care provider. I grant permission for my child's health care provider to share information about the administration of this medication with the school staff. I understand that it is my responsibility to furnish the medication as described below:

Prescription Medication: Must come in the original pharmacy labeled container with: child's name, name of medicine, time medicine is to be given, dosage, date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label.

Over the Counter Medication: Must be labeled with the child's name. Dosage must match the signed health care provider authorization, and the medicine must be packaged in the original container.

I understand it is my responsibility to note the expiration dates of medications sent to school and replace them before they expire.

______________________ ____________

(Signature of Parent/Guardian) (Date)