Fordyce School District
Medication Form

NOTE: A separate form must be completed for each medication administered

Student's Name _____ Date of Birth _____ Grade _____

Hospital to be called _____ Phone _____

Physician to be called _____ Phone _____

Name of Medication _____ Dosage _____

Time to be taken _____ Ordering Physician_____

Physician's Signature_____ Date_____

Reason for Taking Medication _____

Parent/Guardian_____

Cell _____ **Work** _____

In case of an Emergency, contact _____Phone #_____

-The school nurse has my permission to take a photograph of my student for identity purposes to be kept with child's medication administration record.
-I certify that ***at least one*** dose of the medication has ***previously been given*** and **NO** adverse reactions were experienced. Therefore, I give permission for the school nurse to administer the above medication to my child.
-I acknowledge that the District, its Board of Directors, and its employees shall be immune from civil liability for damages resulting from the administration of medications in accordance with this consent form.

***** PLEASE NOTE: Physicians orders and Parent Permission are valid for the current school year and MUST be updated each year. Medications MUST BE in the container labeled by the pharmacist with current date. Over the counter medication must be in original container with label and seal intact. Medications will be administered according to physician's orders only. Medications must be brought to the school by an adult/person over the age of 18. DO NOT SEND MEDICATIONS WITH STUDENTS!!!**

_____ _____

Signature of Parent or Guardian **Date**

Date	Pill Count	Brought by	Bottle Home	Initials/Initials	Comments