

**4.35F-MEDICATION ADMINISTRATION CONSENT FORM**

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_  
Parent Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**This form is good for this, the 2018-2019 school year. This consent form must be updated anytime the student’s medication order changes and renewed each year and/or anytime a student changes schools.**

Medications, including those for self-administration, must be in the original container and be properly labeled with the student's name, the ordering provider's name, the name of the medication, the dosage, frequency, and instructions for the administration of the medication (including times). Additional information accompanying the medication shall state the purpose for the medication, its possible side effects, and any other pertinent instructions (such as special storage requirements) or warnings.

**I hereby authorize the school nurse or his/her designee to administer the following medications to my child.**

**Name(s) of medication(s):** \_\_\_\_\_

**Name of physician or dentist (if applicable):** \_\_\_\_\_

**Dosage:** \_\_\_\_\_

**Instructions for administering the medication:** \_\_\_\_\_

**Please check any of the over the counter medications listed below your child has permission to take while at school.**

Acetaminophen (Tylenol)	<input type="checkbox"/>	Ibuprofen	<input type="checkbox"/>	Cough Drops	<input type="checkbox"/>
Diphenhydramine (Benadryl)	<input type="checkbox"/>	Antacid (Tums)	<input type="checkbox"/>		

**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.**

**Parent or legal guardian signature** \_\_\_\_\_ **Date:** \_\_\_\_\_