MEDICATION ADMINISTRATION CONSENT FORM

STUDENT INFORMATION

Student Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

School: _____ Grade: _____ Teacher: _____ School Year: _____

List any known drug allergies/reactions: _____Height (inches): _____ Weight (lbs.): _____

Parent Name: _____ Phone Number: _____

PHYSICIAN AUTHORIZATION

(To be completed by physician/licensed prescriber)

Name of Medication: _____ Reason for taking: _____

Dosage: _____ Route: _____ Time(s) and Interval to be administered: _____

Date of Authorization: _____ Begin/End Dates: _____

Special Instructions for Administration and Storage of Medication:

Is medication necessary to be given during school hours (7:30 AM to 3 PM)? Yes ☐ No ☐

If yes, please provide recommended administration time(s): _____

Is the medication a controlled substance? Yes ☐ No ☐ Does medication require refrigeration? Yes ☐ No ☐

Special Instructions or Storage: _____

Potential Side Effects/Contraindications/Adverse Reactions: _____

Treatment Order in the event of an adverse reaction: _____
(Attach additional sheet or use the back of this form if necessary)

Provider Name: _____ Provider Signature: _____

Phone Number: _____ Date: _____

PARENT AUTHORIZATION

(To be completed by parent/guardian)

- I authorize the delegated personnel the task of assisting my child with medication administration.
- I agree to notify the school if I change physicians or if the prescription is changed or discontinued.
- Only medication prescribed and provided by the United States will be administered in school.
- Medication that is expired or has a listed discard date will not be administered to students past indicated date.
- Prescription medication must be in the original container with the pharmacy (U.S.A. only) label. The container must have a proper label with the name of the patient, the name of the medicine, and the dosage.
- Administration consent form must be completed and signed by physician, parent, or legal guardian. **NO VERBAL CONSENT OR PHONE CONSENT WILL BE ACCEPTED.**
- Medication will be kept in a secure place in the health clinic during school hours. No medication shall be held in classrooms or backpacks at any time. Any medications brought in by students or found in a student's possession will be taken to the health clinic and remain in the clinic until a parent signs the consent form or picks up medication.
- Only students with written authorization from their physician and parents are allowed to self-carry medications. This authorization shall be provided to the clinic prior to the student's ability to self-carry emergency medications.
- It is the parent or guardian's responsibility to deliver the medication to the school health clinic and have the medication picked up at the end of the year. Medication not picked up by the end of the year will be discarded.
- The first dose of any new medication shall not be administered at school due to the possibility of an allergic reaction.

Parent/Guardian Name: _____ Parent/Guardian Signature: _____

Secondary Contact Number: _____ Date: _____

MEDICATION ADMINISTRATION CONSENT FORM

STUDENT INFORMATION

Student Name: _____ Date of Birth: _____
(Nombre del Estudiante) *(Fecha de Nacimiento)*

Address: _____ City/State/Zip: _____
(Dirección) *(Ciudad/estado/codigo postal)*

School: _____ Grade: _____ Teacher: _____ School Year: _____
(Escuela) *(Grado)* *(Maestro/a)* *(Año escolar)*

List any known drug allergies/reactions: _____ Height (inches): _____ Weight (lbs.): _____
(Alergia/Reacción Conocida a Medicamentos) *(Altura)* *(Peso)*

Parent Name: _____ Phone Number: _____
(Nombre del Padre) *(Número de Teléfono)*

PHYSICIAN AUTHORIZATION
(To be completed by physician/licensed prescriber)

Name of Medication: _____ Reason for taking: _____

Dosage: _____ Route: _____ Time(s) and Interval to be administered: _____

Date of Authorization: _____ Begin/End Dates: _____

Special Instructions for Administration and Storage of Medication:

Is medication necessary to be given during school hours (7:30 AM to 3 PM)? Yes ☐ No ☐

If yes, please provide recommended administration time(s): _____

Is the medication a controlled substance? Yes ☐ No ☐ Does medication require refrigeration? Yes ☐ No ☐

Special Instructions or Storage: _____

Potential Side Effects/Contraindications/Adverse Reactions: _____

Treatment Order in the event of an adverse reaction: _____
(Attach additional sheet or use the back of this form if necessary)

Provider Name: _____ Provider Signature: _____

Phone Number: _____ Date: _____

AUTORIZACIÓN DE LOS PADRES
(Para ser completado por el padre/tutor)

- Autorizo al personal delegado la tarea de asistir a mi hijo en la administración de medicamentos.
- Acepto notificar a la escuela si cambio de médico o si la receta se cambia o se interrumpe.
- Sólo se administrarán en la escuela los medicamentos prescritos y proporcionados por los Estados Unidos.
- Los medicamentos que estén vencidos o que tengan una fecha de descarte indicada no se administrarán a los estudiantes después de la fecha indicada.
- Los medicamentos recetados deben estar en el envase original con la etiqueta de la farmacia (solo en EE. UU.). El envase debe tener una etiqueta adecuada con el nombre del paciente, el nombre del medicamento y la dosis.
- El formulario de consentimiento de administración debe ser completado y firmado por un médico, padre o tutor legal. **NO SE ACEPTARÁ CONSENTIMIENTO VERBAL NI TELEFÓNICO**.
- Los medicamentos se mantendrán en un lugar seguro en la clínica de salud durante el horario escolar. No se guardarán medicamentos en las aulas o mochilas en ningún momento. Cualquier medicamento traído por los estudiantes o que se encuentre en posesión de un estudiante será llevado a la clínica de salud y permanecerá en la clínica hasta que un padre firme el formulario de consentimiento o recoja el medicamento.
- Solo los estudiantes con autorización por escrito de su médico y sus padres pueden llevar sus propios medicamentos. Esta autorización se proporcionará a la clínica antes de que el estudiante pueda llevar consigo los medicamentos de emergencia.
- Es responsabilidad del padre o tutor entregar el medicamento a la clínica de salud de la escuela y recoger el medicamento al final del año. Los medicamentos que no sean recogidos al final del año serán desechados.
- La primera dosis de cualquier medicamento nuevo no se administrará en la escuela debido a la posibilidad de una reacción alérgica.

Parent/Guardian Name: _____ Parent/Guardian Signature: _____
(Nombre del Padre de Familia / Guardian) *(Firma del Padre / Tutor)*

Secondary Contact Number: _____ Date: _____
(Número de Contacto Secundario) *(Fecha)*