MEDICATION CONSENT FORM

CENTRAL C.U.S.D. #4 SCHOOLS
155 E. FOURTH AVE. P.O.BOX 637 CLIFTON, ILL. PHONE: (815) 694-2231 FAX (815) 694-2844

THIS PORTION TO BE COMPLETED IN FULL BY PARENT/GUARDIAN

- I understand that if my child must receive medication at school it may be necessary for a non-certified/non-licensed person to administer the medicine or to assist my child in self-administration of the medication described below.
- I understand that any medication to be taken at school must be brought to school by me in a properly labeled container. Prescription medications must be brought to school in a pharmacy labeled container. Both types of medication MUST BE ACCOMPANIED BY A PHYSICIAN ORDER (see form below).
- I understand it will be my child's responsibility to go to the office where all medication is to be kept until it is administered at the prescribed time under the supervision of a designated employee of the School District.
- I understand that the Central School District has the right and responsibility to refuse to administer any medication if all proper procedures and safeguards are not followed.

STUDENT NAME_____GRADE IN SCHOOL_____
PHYSICIAN'S NAME_____SCHOOL CHILD ATTENDS_____
NAME OF MEDICATION_____
DIAGNOSIS REQUIRING MEDICATION_____
DATE OF PRESCRIPTION_____DISCONTINUATION DATE_____
DOSAGE_____TIME(S) ADMINISTERED_____

THIS MEDICATION (please check one) CAN BE SELF-ADMINISTERED (WITH SUPERVISON)_____
MUST BE GIVEN BY SCHOOL PERSONNEL_____

I GIVE MY PERMISSION FOR MY CHILD TO RECEIVE MEDICATION AT SCHOOL IN COMPLIANCE WITH THE DIRECTIONS PROVIDED ABOVE AND SPECIFICALLY CONSENT TO ADMINISTRATION BY AN INDIVIDUAL OTHER THAN A SCHOOL NURSE.

_____ _____
Parent Signature Date

THIS PORTION TO BE COMPLETED BY PRESCRIBING PHYSICIAN

PHYSICIAN'S ORDERS FOR ADMINISTRATION OF MEDICATION AT SCHOOL

NAME OF STUDENT PATIENT_____
DIAGNOSIS AND DATE SEEN_____
MEDICATION(S) PRESCRIBED_____
INTENDED EFFECT/BENEFIT OF THIS MEDICATION_____
_____

DOSAGE(S)_____TIME(S) OF DAY ADMINISTERED_____
SIDE EFFECTS_____
_____
(use reverse side for explanation if necessary)

_____ I UNDERSTAND THIS MEDICATION WILL BE GIVEN BY SCHOOL PERSONNEL OTHER THAN A CERTIFIED SCHOOL NURSE
_____ THIS MEDICINE MAY BE SELF-ADMINISTERED BY THE STUDENT WITH ADULT SUPERVISION

PHYSICIAN'S SIGNATURE_____DATE_____

Physician's Office Phone Number_____ Physician's Emergency Phone Number_____