MEDICATION CONSENT FORM

CENTRAL C.U.S.D. #4 SCHOOLS
P.O. BOX 158 ASHKUM, ILLINOIS PHONE: (815) 698-2212 FAX: (815) 698-2635

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 SUPERVISION) _____

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 _____