Southeast Fountain School Corporation

Medication Consent Form

Board Policy stated, "Prescription medication given at school **MUST** have written, dated consent with instructions of the physician and parent on file in the principal's/nurse's office. Nonprescription medications may be given only with written, dated permission of the parent or guardian. This medication **MUST** be in the original bottle with the manufacture's label and the student's name affixed. No medication shall be given without this information. Medication will be kept secure in a cabinet or refrigerator and administered by the school nurse, the principal, or designated staff**. ALL MEDICATIONS MUST BE KEPT IN THE ORIGINAL CONTAINER. THE PARENT/GUARDIAN IS RESPONSIBLE TO DELIVER ANY CONTROLLED MEDICATIONS TO THE SCHOOL AND NOT TO BE SENT WITH THE STUDENT. ALSO, IT IS THE PARENT'S RESPONSIBILITY TO PICK UP ANY UNUSED (CONTROLLED) MEDICATIONS AT THE END OF THE TREATMENT REGIME. IF THESE MEDICATIONS ARE NOT PICKED UP BY THE END OF THE SCHOOL YEAR, THEY ARE DISCARDED**. Medications shall be administered in accordance with the physician's prescription. Any changes require written, dated authorization from the physician and the parent. **MEDICATION SHOULD BE GIVEN AT HOME WHENEVER POSSIBLE."** Medication given during school hours should only be those necessary to help the student maintain an optimal state of health to enhance his/her educational program.

I request that the medication described below be administered to my child at the dates and times specified. I will provide this medication in the original container. I understand that this consent is valid for one year and must be renewed whenever there is a change made in this medication. I also give consent for school personnel to speak to the physician listed below in regards to any questions or concerns that may occur while taking this medication.

Student's Name ____________________________ School ________________________

Name of Medication _________________________ Days to Be Given _______________

Prescribed _____ Over-the-Counter ______ Refrigeration Required YES___ NO ___

Time To Be Administered _____________ Amount to be given ___________________

Purpose of Medication ____

Physician's Name __________________ Physician's Telephone # __________________

Pharmacy ____

This medication is to be given to my child only until _____________________ (day/date)

Parent's/Guardian's Signature ____

Phone # ___________________________ Date ________________