PARENTAL CONSENT TO ADMINISTER MEDICATION AT SCHOOL

Scheduled Medications

Today's Date: _____

Parent or guardian's name (please print):

_____

Child to receive medication: _____

List *any known allergies* that your child has (including food allergies):

_____

List *any medical conditions* affecting your child (for example, asthma, seasonal allergies, heart trouble, diabetes, etc.):

_____

1. ***Name*** **and** ***strength*** **of the medication: _____**

2. ***Amount*** **(or dose) of medication to be given: _____**

3. **What** ***time(s)*** **should the medication be given? _____**

4. ***For what condition*** **is your child receiving this medication?**

_____

5. **This medication consent will remain in effect** ***until*** **_____**

Parent / Guardian Signature: _____

Email Form