Consent for Medication Administration

Student: _____ Grade: _____
Teacher: _____

I authorize the School Nurse/Principal/Teacher of Creekside Christian School to administer the following to my child:

Medication: _____ Dose: _____

Time: (check and fill in correct time/reason for medication)
1) _____Medication at _____o'clock.
2) _____As needed to control asthma or wheezing but no more often than every 4 hours.
3) _____As necessary for_____

- Prescribed medication will be provided in the original container stating the name of the medication, student's name, the name of the pharmacy, physician's name and the dose to be given.
- Over-the-counter medications will be in the original store container and in an age appropriate form and dose.
- Consents for cough medications will be good for a maximum of 2 weeks.
- The first dose of any medication must be given by parent/guardian.
- Parent/guardian is responsible to pick up medications from school.

I absolve the school personnel of all responsibility for any unforeseen development/reaction due to the administration of the above named medication. It is the responsibility of the child to come to the office to take his/her medication.

Authorization start date _____ Authorization end date _____

Parent/Guardian Signature: _____Date: _____