

(Refer to Policy IHCD, Procedure 3. b)

Student's Name: _____

Name of Medication: _____

Purpose of Medication: _____

Amount to be Administered: _____

Administration Time: _____

Possible Side Effects: _____

Storage Instructions: _____

Termination Date for Administration of Medication: _____

Student's Ability to Self-Administer: _____

I confirm that I have the authority to sign this consent and will inform any other parent or guardian of the contents of this consent and the fact it has been signed.

Parent/Guardian Signature: _____

Date: _____

Doctor's note confirming above information must be attached (copy to Student Record.) OR the Doctor can sign this form:

Date Doctor's note verified: _____

Refer to Policy IHCD Procedure 3. b)

The student's physician affirms that administration of medication to the student as requested by the parent is within the competence of an adult untrained in medical procedures.

Doctor's Signature: _____

Date: _____

Notes:

- Contact parent if extra dose is required (i.e. student forgot to take morning dose at home).
- All medication should be kept in an appropriately secure manner.
- Principal must review and initial the Medication Administration Record on a regular basis.

